
Perfect
An alternative perspective
on mental health & addiction

Dedicated to Raph, Chris and all the others lost along the way because of misinformation and unethical practice.

And to my beautiful children.
I wish I had known then, what I know now.

What's this all about?

I have fully recovered from anxiety and depression that was so bad at one point … I was almost diagnosed with BiPolar.

I've done extensive research — and personal practice — into this content for (now) nine years in total and am releasing a short book on the key points I discovered for free.

Perfect: An alternative perspective on mental health and addiction.

I feel it's important to share this information as quickly as possible. For free because, often, those that may need it most may not be able to afford it. My editor keeps telling me people will think it is a load of rubbish if it is free, because human beings place value on how expensive things are.

He has a valid point.

This is a commonly known, interesting misconception us humans still buy into.

“If it is expensive, it must be valuable.”

I’ll leave you to consider whether the above statement rings true for you.

The Research

I researched the full history of the (DSM).

Learning how and why the DSM was developed, and how it’s edited to stay current, really changed my perspective on mental health in full.

The history of psychology and psychiatry is very interesting indeed…

In addition:

1. What defines a disease, the neurology of the brain with regards to a variety of mental disorders and addiction, as well as the physiology of the brain in relation to these
2. Symptoms of mental disorders / classification and diagnostics
3. Developmental and Relational trauma

4. Hereditary trauma
5. Dysfunctional family “roles”
6. Emotional and psychological abuse
7. Codependency
8. PTSD/C-PTSD and the effects on the physiology of the brain and nervous system
9. Psychology and its various schools of thought/theory (and some of the academic papers from these that rang true)
10. Plant medicines and the effects on the brain / in therapeutic treatments
11. Diet and the effects on the brain and nervous system
12. Physical exercise and the effects on the nervous system and brain
13. The mind/body link

I did detailed (four hours minimum, some over some days) background histories with four other dual diagnosis cases (addiction and — a Schizophrenic, two BiPolars and a BPD)

What therapies/practices I both used personally, and/or researched at various times over the eight years

- AA & NA (12 Step Program)
- Adult Child
- SLAA
- CODA
- EDA
- The PolyVagal Theory

- EMDR
- TRE
- Plant medicines
- Yoga & breath-work
- EFT — “Tapping”
- Hypnotherapy
- Talk therapy / Counseling
- Movement Medicine / Conscious Dance
- DBT
- Started a CBT course — unfinished
- NLP
- A variety of meditation techniques (Transcendental; Vipassana)

I’ve used my approach with one client who was open to testing it. He has not had a drink since December 2021, has not needed treatment or any support groups and no longer feels any anxiety.

While I initially asked him to participate because he is an extremely courageous and resilient individual, who has an incredible capacity for self reflection, I now strongly believe that the perspective and approach I’m sharing with him will work for many others as well.

A great deal faster.

Foreword

I’ve been trying to write this book and share information both found via research, and learned through trial and error, for some years now.

The format has changed, over the years, from a single person retelling of a journey of self discovery and healing, to a third person story that may be less confrontational for institutions, professionals, and the general public to consider engaging with.

I thought, in this less direct way, I could list the questions I asked with some curiosity and simply show the information I discovered in my search for some answers, the interesting connections I made and the somewhat astounding recovery that followed.

The purpose of the revised format was to inspire others to ask similar questions, with a different perspective on addiction and mental health, to encourage them to research for themselves and see if our answers were similar or even the same.

What happened next, was yet another enormous progression in my personal recovery.

At this stage, I lost all interest in retelling my story or even trying to share the answers I'd found. I was tired of revisiting painful parts of what was fast becoming ancient history for me. I was also integrating the learning and moving forward so quickly, it began to seem self indulgent and counterintuitive to keep going over the past vividly enough for it to be of any real value to others.

I had also begun to accept how complicated this conversation is.

During these years of doing and redoing, I began to write on a platform on the internet.

As I met fellow writers online, with similar stories and perspectives, I became even more aware of how big this topic is and how deep the proverbial rabbit hole goes. It also brought home to me how resistant both the medical profession and the general public are to discuss why addiction and mental disorders are on the increase and current treatments are often failing. And the increase in psychiatric medication being prescribed as standard practice these days.

More procrastination followed.

How was I to share my findings, if the majority of people aren't even willing to talk about these topics?

A professional editor appeared in my radius.

A fellow human who had been through a similar experience regarding the apparent loss of direction in the mental health and addiction industry.

I asked him to edit the book and he very kindly consented.

I sent him an already written forward.

He's tough. This guy's experienced and he knows what's what. My first attempt at the book's Forward didn't make the grade.

I rewrote it and submitted another version. Still no go.

My editor's feedback has been entirely and soundly spot on with every response. He sees the pitfalls of trying to write a book like this and he's methodically and accurately pointed them out at every turn.

I knew he was spot on because I'd already experienced some of the questions he's raised in live situations for the past three years as I've tried to share some of this. As for the rest, I just trust his judgment because I'm not a professional writer.

He asked me, in one of many emails as we discussed the difficulties, what I'm even precisely trying to say. A valid question as there's a lot to be said and the content is not specific to just one topic.

But then neither is proper recovery for mental health and addiction as it turns out.

His question was raised during a discussion on the fact that I couldn't say what I want to because I'm not a doctor and, consequently, I won't be taken seriously.

I know this of course.

I'd already looked at studying to get a PhD in order to bring this to you as a fully fledged doctor, just so you might consider believing me. Sadly, I'm unable to afford the costs. Perhaps one day…

But my editor's question on what exactly I'm trying to say has sat with me for a few weeks since my last attempt to get the Forward (at least) written.

What am I trying to say?

That addiction is not a disease and the plethora of diagnoses in the Diagnostic and Statistical Manual of Mental Disorders are not disorders in the way we believe they are.

But I'll be ignored because I am not a doctor.

Realistically, even if I were on par with the medical fraternity, disagreeing with current practices to this extent would probably see me ostracized and called a "quack."

I'm trying to say that psychology is not a science and we're being incorrectly led to believe, often by medical professionals themselves, that psychological problems are medical problems.

But the general public won't believe me because we've been taught to respect authority without question and I'm not a doctor. Again.

I'm trying to say that you can't separate the human mind from the human body/physiology and external environment and expect to cure anything or anyone.

I'm saying that perspective is, literally, everything with regards to adequately treating these conditions and that our "modern" approach is totally off the mark.

I'm trying to share that facilities and programs aimed at "treating" these conditions are falling short because they're not only not seeing the full picture, but are actively keeping people sick because they are completely (and sometimes intentionally) avoiding a large part of the problem.

I’m trying to say that the majority of the professionals I’ve approached over the years for guidance caused more harm than good, because they’ve been given the wrong information in their studies and are poorly trained with only parts of, or none of, other important information.

I’m trying to say that a lot of these professionals know this, but are sticking to the status quo because they’re afraid to be ostracized by the rest.

I’m trying to say the treatment of addiction and mental health has become an industry driven by financial gain and that people are regularly being incorrectly diagnosed and put on expensive pharmaceutical medication for lifetimes because of human greed.

While, at times, many professionals (and one group) gave me tools and small bits of information that did help me progress, they never did “fix” or address the real causes of my addiction and enormous variety of mental diagnoses.

The thing is, the more I share about this topic, the more I come to understand that many of you know all of this anyway.

So my question would be, why are you still buying into all of this medical advice if psychiatric disorders and addiction are on the increase? And if most of you know that current treatments are seriously questionable?

Because you do know this already. A lot of you have told me in person.

I’m just going to put it down, in black and white, to remind you when things get a bit confusing.

Because I’m not a doctor.

I’m just a Schizophrenic, BiPolar, Borderline, Anxiety & Depression Disordered, Addict who, somehow, is sitting writing this today, almost three years medication free and no further treatment necessary.

Which means you probably won’t believe me when I tell you there is, probably, nothing wrong with you either.

If you don’t quite believe me, yet, I invite you to read on a bit to see why I believe this may be true.

1

Basic Instinct

“You are not suffering from a disease or disorder and I’m going to tell you why,” I say.

Mostly — people laugh at me. And hardly anyone believes me if they’re polite enough to not laugh in my face. They humour me instead.

This is the common reaction when I try to share my perspective on mental health and addiction, even though there’s more than enough information to support my perspective and I’m walking proof my approach works.

I believe this happens because not many other people have taken the time to find out more about how the psychiatric industry decides what a disorder is and how it should be decided whether a person has one or not.

Nobody seems to question this at all, except a few people who've been misdiagnosed and have taken the time to find out more about how this could have happened to them when doctors were supposed to have known better.

Currently, many doctors and psychologists are telling people they have some kind of mental disorder that is incurable and requires medication for life as standard practice.

Currently, the general public have come to accept mental health challenges as mental "illnesses" or "disorders", because that is what doctors and psychologists have been calling these things for some years now.

I've disagreed with this perspective on mental health and addiction being a disease or disorder for some time now, and I share my opinion freely and often. I also share it with clients, who are struggling with addiction and mental health, who come to me for guidance.

"You are not suffering from a disease or disorder and I'm going to tell you why," I say.

And they also generally react in the exact same way, while I sit and observe their responses silently, wondering…

how they expect to get well if they don't even believe this is possible themselves.

Until recently, I also struggled to believe this was possible myself.

I’m not referring to a variety of mental health reactions or addiction being curable, but that “truth” can be so mutable and impermanent. That truth can even change entirely, depending on understanding and perspective.

These days, I’ve come to accept that people believe what is “safest” for them to believe, despite evidence and facts being presented to them that may contradict a belief. In fact, this need to feel safe pretty much governs every aspect of every decision we make.

Is this safe or is this dangerous?

Left or right? “Like” or keep scrolling?

We humans like to separate ourselves from animals. We tell ourselves animals are just instinctual beasts, while we’re able to intellectualize, rationalize, make decisions, adapt our surroundings to suit us and invent things to progress our societies and civilisations.

But what if we kept it simple and thought of ourselves as animals as well?

With the same main motivation any other animal has...

to survive.

Basic Instinct

American physician and neuroscientist Paul D. MacLean suggested a model of the evolution of the vertebrate forebrain, and behaviour associated with it, and called it “The triune brain”.

> *Like any scientific model, this has been subject to criticism and has even been called “one of the most successful and widespread errors in all of science.”* [1]

Dr MacLean’s model expands the triune brain to be made up of: the reptilian complex (or lizard brain), the paleomammalian complex (limbic system), and the neomammalian complex (neocortex).

Have I lost you yet?

Because it just becomes more complicated from here.

Each of these three areas also have subsections and, following those, we get into neurochemicals and more.

It’s a lot.

So what if we just keep it simple?
If I’m suggesting we’re like any other animal, with our main motivation and underlying drive being survival, we need only focus on two areas of the brain for this conversation.

Before we do that I want to clarify I'm keeping things so simple, that I'm saying EVERY choice we make has just ONE primary core MOTIVATION.

To SURVIVE at all costs.

For this conversation then, we only need to consider the areas of the brain that are now believed to be associated with survival.

And these same areas of the brain are directly linked to cognitive function and behaviour and, as it turns out…

they're directly related to mental health and addiction as well.

The Human Survival Mechanism

The Command Center

When someone experiences a stressful event the amygdala, an area of the brain that contributes to **emotional processing**, sends a distress signal to the hypothalamus.

Harvard Health Publishing says it simply and concisely:

“The hypothalamus is a bit like a command center.

This area of the brain communicates with the rest of the body through the ***autonomic nervous system****, which controls such involuntary body functions as breathing, blood pressure, heartbeat, and the dilation or constriction of key blood vessels and small airways in the lungs called bronchioles.”* [2]

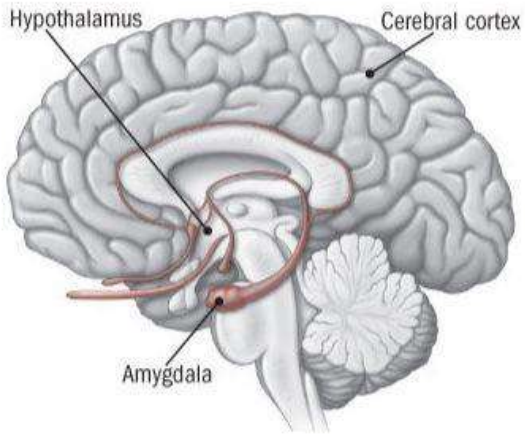


Image from Harvard Health Publishing | Harvard Medical School

In other words, the autonomic nervous system controls the body’s response to a perceived threat and regulates the body’s responses after the threat has passed.

The Autonomic Nervous System

"The autonomic nervous system has two components, the sympathetic nervous system and the parasympathetic nervous system.

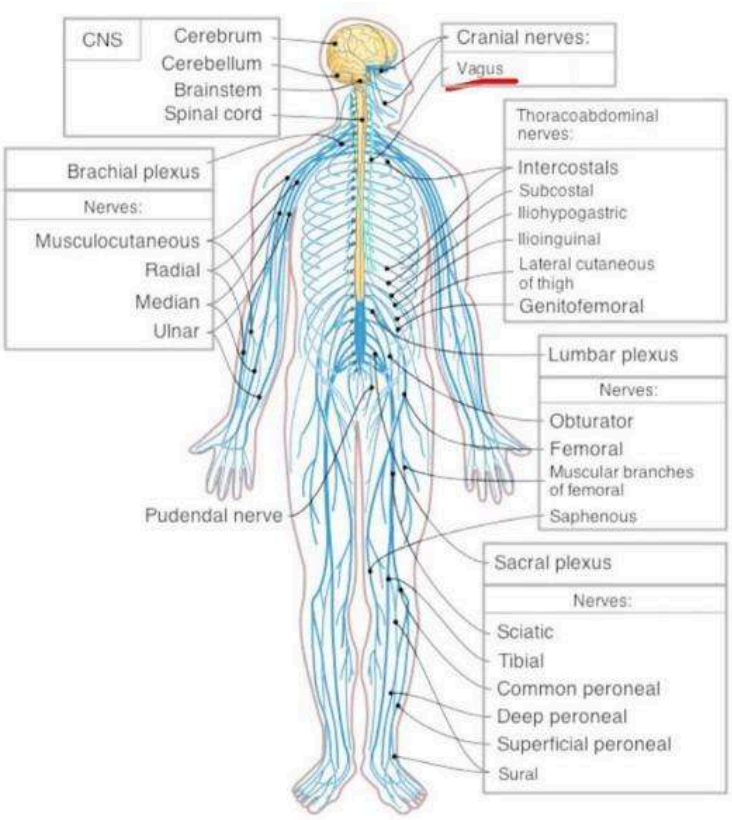
The sympathetic nervous system functions like a gas pedal in a car.

It triggers the fight-or-flight response, providing the body with a burst of energy so that it can respond to perceived dangers.

The parasympathetic nervous system acts like a brake.

It promotes the "rest and digest" response that calms the body down after the danger has passed. [3]

All of these changes happen so quickly that people aren't aware of them. In fact, the wiring is so efficient that the amygdala and hypothalamus start this cascade even before the brain's visual (audio, olfactory)[added by me] *centers have had a chance to fully process what is happening. That's why people are able to jump out of the path of an oncoming car even before they think about what they are doing."* [4]



The nervous system

Image by Medium69, Jmarchn - File:Nervous system diagram.png, CC BY-SA

When we see a diagram of the nervous system, it’s clear the mind and body are, literally, connected.

Our understanding and translation of the world around us, (the mind/perception) is created by past experience and our external circumstances, and environment, at any given time. The brain’s reactions, and the various chemicals released at specific times, are a response to our mind/perception of our external circumstances and environment.

And our bodies are wired to respond appropriately to commands from the brain, to keep us safe.

And alive.

All of these are linked and work in unison with this same motivation.

Survival.

Yet, in Western society, we've come to imagine and treat the mind, brain and body as separate entities.

We have different specialists and even completely different types of professionals (GP's, psychologists and psychiatrists for example), focusing on different areas of interest, with little to no consideration for the other parts of the whole organism…

or even external circumstances at times.

But in this short explanation, which is only a tiny oversimplification of how the brain and nervous system work together, we already see that a variety of the body's physical responses are controlled by only one perception of the mind (danger/safety) and a subsequent reaction in the brain/nervous system.

So it would appear to follow that if the mind impacts the brain's reactions and the brain impacts the body's reactions, one could reverse this and impact the mind via the body in turn.

This is how health concerns are more commonly approached and treated in other parts of the world, by the way.

A holistic questioning, and resultant understanding, of ***why*** someone has reactions like anxiety, depression and addiction is one of the approaches that could be used to get people well in full.

But in the West we've been led to believe that this type of approach is unscientific.

The general perspective is that holistic treatment is not ***real*** medicine.

And, even though there are Western doctors who've begun to look at the bigger picture by considering the "whys?" of certain conditions, the broad consensus is that the mind, brain and body generally function, and should be treated, independently.

Still.

Despite them being directly linked together via our nervous system.

Which ***is*** science.

Even knowing about the physical mind/body connection, many people still think what I am trying to share to be implausible, simply because we've never taken the time to have a look at these things more logically.

Or have thought to ask more questions about how mental health and addiction may work for ourselves.

I should add here that I've repeatedly argued about mainstream perspectives on mental illness with a dear friend who achieved a hard won clinical psychology qualification. The deeper connection between the mind and the physical reactions of

the body **was never a part of his curriculum**. And he never thought to question **why** people have mental disorders either.

> In fact, he couldn't understand how someone could have anxiety at all.
>
> **Or even what it is or how it feels**.

This is because he hasn't had any **personal** experience with any of the mental disorders so regularly given as diagnoses to people suffering.

He's never suffered from anxiety. Nor has anyone close to him, in order for him to be exposed to the reaction long enough for any kind of deeper understanding of it to be imparted. It has never been a part of his own experiential learning.

His education thus far has only been textbook notes.

And this is the same for the vast majority of professionals, who are trying to help people with mental health and addiction challenges.

> Just like the majority of psychiatrists or psychologists who also earned those hard won certificates, this dear friend was given one specific book to refer to and his view on what mental reactions are is directed by this book alone.

As a result when he talks to people he is ***immediately*** looking for a diagnosis, as per his education by this particular book, from the very beginning of the conversation.

This book is used to diagnose people with mental health challenges in our society, you see. It's so widely used in fact, it's also known as the "Bible of psychiatry and psychology". Every student who enters a modern classroom to study psychology or psychiatry, in almost all Western countries, is given one as standard text.

And when they're practicing as qualified professionals in many countries worldwide, they buy the latest version as this book is updated, to stay current with the ***new*** mental disorders and categorisation of them that the book contains in the latest edition.

And which ones have been removed.

Yes. **Removed at times**.

The formal and full title of this book is "The Diagnostic and Statistical Manual of Mental Disorders".

Commonly known as the **DSM**.

But we'll talk a bit more about that in the next chapter.

What I'm suggesting you consider, in this chapter, is that **it's possible to control the brain and the mind via the body**.

One can take prescription medication to dull down the brain's reactions, or one can use physical action and tools directly with and on the body to simply regulate the nervous system instead.

To understand more how this might work, we need only focus on one particular nerve, because this nerve interfaces with the parasympathetic nervous system and can control the responses of the heart, lungs, and digestive tract.

While the amygdala and hypothalamus, the two areas of the brain we referred to as the “Command Center” earlier, set the sympathetic nervous system into Fight/Flight (the stress response) at a perceived threat…

The Vagus Nerve manages the parasympathetic (safe and regulated) control of the heart, lungs and digestive tract to ease the body into rest again when a perceived threat has passed.

By directly stimulating the Vagus Nerve, based on Dr Stephen Porges’ Polyvagal Theory, one can calm the stress response simply, quickly and effectively.

Action based tools and therapies that work directly on regulating the nervous system through physical movement, postures, controlled breathing, use of temperature and sound / vibration work very effectively indeed.

DBT (Dialectical Behaviour Therapy) uses similar methods, and combinations of these, in its approach. It also includes additional CBT (Cognitive Behavioural Therapy) based thinking and tools, which are often too difficult to put into action during a severe anxiety attack, because a person’s mind is either racing or zoned out during these moments.

It’s often not possible to use your rational brain, and cognitive tools, while your “lizard brain” is running the show. Physical intervention, directly on the nervous system, is fast and easy to use during times of major stress and anxiety/depression.

This is not, as we have been led to believe, all “mental”.

I didn’t invent these rational connections or write some new theory on mental health. These methods have all been around and freely available for some time. These are simply not popular topics in psychology classrooms.

There are a great many well qualified and highly acclaimed professionals who are outspoken in their concerns about mainstream thinking, and treatment for mental health, and the reasons it has drifted away from what used to be very effective standard practice over the years.

And why.

I didn’t invent all of this and this is not my work.

I’m sharing this with you, because finding this information is what led me into permanent and lasting health and others shared it with me to get where I am today.

Yet no doctors, psychologists, psychiatrists or addiction specialists (who I personally asked) had heard of either of the two main sources of information I found during my endless searching. And both resulted in me finding treatments that have far better and even lasting results for recovery.

Some of the practices I use and share with clients, that work directly on the nervous system itself, are still considered “esoteric” or plain quackery. Yet, there are many other people who’ve also managed to find healing that is more permanent with these approaches.

I speak of trauma informed approaches to mental health and addiction, instead of the current medical approach that these are disorders or diseases of course.

I think it might be helpful to expand a bit on what trauma actually is, since ***many people aren't even aware they have trauma***.

But before we get to that point, I'd like to clarify how one can find mental and emotional stability during a stressful event or after being "triggered" by working directly with the nervous system.

Specifically the parasympathetic nervous system.

Self controlled physical intervention, by using simple tools and movement directly on the nervous system, is fast and easy to use during times of major stress and anxiety/depression/mental and/or emotional dysregulation.

Remember this sentence from the beginning of this chapter:

> *"When someone experiences a stressful event the amygdala, an area of the brain that contributes to* ***emotional processing****, sends a distress signal to the hypothalamus."*

If we're working from the body back to the mind, instead of trying to medicate the mind to just dull down its reactions…

We regulate the nervous system (using physical tools and actions) and calm the hypothalamus…
the amygdala (which contributes to emotional processing), calms down…

And a person becomes “emotionally regulated” again **mentally**.

This works!

Anyone can focus, specifically, on their nervous system responses and maintaining physical, and hence emotional, regulation to manage stress, triggers or episodes by managing the nervous system alone.

Over time one gets to know exactly what triggers a stress response in an individual and the primary causes of the triggers can be found and dealt with directly, to alleviate the stress reactions permanently.

Many people try to do this in therapy as “shadow work” which is invaluable and a real way to lasting health and peace. But this kind of personal growth can also take a really long time due to the nature of the mind and its unwillingness to sit with pain.

Its natural response is to avoid pain (danger) to survive, according to this simple explanation of how all of this may work.

The mind will avoid painful situations, past or present, at all costs in its attempts to protect the individual. This is the “denial” that both therapists and their clients find it hard to break through, in order to make real and lasting changes.

But while the mind can be extremely slippery for reasons that are quite beautifully logical and instinctively rational (survival) …

the nervous system can not lie.

This also explains why, even on the anxiety meds, some people ***still*** have panic attacks.

This is a part of the approach I use to map out primary traumas and how addictions are linked to them.

There's little chance a person can be self aware, conscious and vigilant enough about observing their own reactions, to make any deep connections at all if they are using alcohol or narcotics regularly, however.

Total sobriety is the first step towards proper recovery for mental health challenges.

And this includes, when the person is stable and ready to come off them, prescription and plant medicines as well.

If a person is using any kind of substance (or addictive behaviour) to regulate their triggers, the root causes (primary traumas) will be much more difficult (if not impossible) to find and address.

While I believe prescription and plant medicines can be very helpful to stabilize and guide a person in the early stages of therapy and recovery, over time they slow down or halt the healing process in full.

**Please do not come off any prescription medication without support and guidance from a trained professional*

When I asked out of interest, a highly qualified psychologist answered that **a proper diagnosis should take up to six months.** A proper diagnosis by the standards of the general psychiatric community utilizing their common methodology.

Yet standard practice in South Africa right now, and I suspect in most Western countries, is an immediate diagnosis and often a prescription for psychiatric medication in the first 45 minute session.

45 minutes. In the first session.

One first 45 minute session isn't enough time to gain insight beyond an individual's own denial and defenses to even know what their reactions to the current life situation may fully be.

One 45 minute session is not enough time to do a proper background history, or find out if there are any physical or environmental reasons for a person's distress.

One 45 minute session, which is generally the standard amount of time allocated for individual therapy sessions, is not even enough time to uncover the truth about how an individual is really doing in a relatively uncomplicated situation.

Not even close.

I work with sessions of between one and a half to two hours at a time intentionally.

It's only close to an hour and a half into a session that a person becomes "tired" enough to start letting things "slip" accidentally. And to start reacting to questions more authentically because of it. People can breeze through a 45 minute session and never let on what ***any*** of the real underlying issues are that really need to be addressed.

Or even if they've had a bad day.

Perhaps this is why psychotherapy has been assumed to not work as effectively as psychiatric medications, when (again, in my experience) it works far better and has far more lasting results. It only takes longer. And medical aids don't pay for those kinds of hours or that kind of time for treatment.

It’s quicker to alleviate the symptoms using drugs instead.

I’ve heard of repeated mis-diagnoses and prescription of chronic medication with harmful and unbearable side effects by a great many people. Some who have lived with extreme discomfort and lost years of their lives because of this, when they really only needed trauma recovery.

In addition, validation of a person’s experience is a key (if not **the** most important) factor in successful recovery from trauma. It goes to follow that telling a traumatized person they are mentally disordered or diseased as part of “treatment” is simply barbaric on every level.

This only re-traumatizes the person suffering and **further** embeds the trauma, making it even more difficult for them to ever fully recover.

Standard practice.

You’re probably wondering what this has to do with you, or your children, since you may not think there is any trauma to address to possibly find relief.

It’s really helpful to understand trauma and the fight/flight response properly for all of this to begin to make more logical sense.

The Stress or Fight-Flight Response

In fact, it shouldn't even be called a response, so for this conversation I'm going to refer to it as a **reaction** instead.

If it were a response, we would have time to consider what behaviour might be most constructive and take that course of action.

But that is not how the Fight-Flight reaction works.

When this reaction is kicked into gear, the "reptile/lizard" brain has taken over and we are acting on "animal impulse".

> *The fight-or-flight-or-freeze or the fight-flight reaction (also called hyperarousal or the acute stress reaction) is a **physiological reaction** that occurs in response to a perceived harmful event, attack, or threat to survival.* [5]

The version of the Fight/Flight reaction I refer to is:

- Fight
- Flight
- Fawn
- Freeze

Different people will have different reactions when they feel threatened.

Usually we use all of these depending on the situation, but most of us will revert to one or two of these that are our primary reactions, when our “reptile brain” takes over to protect us.

So what would you think if I suggested that a variety of so-called mental disorders are, possibly, simply the above fight/flight reactions?

And what if I suggested that addictions are entirely learned behaviours, used as an attempt to find safety when a person has been triggered into these fight/flight reactions?

Most people would laugh at me, politely nod and smile inwardly or ignore such suggestions in full.

Anxiety and addiction are mental disorders, right? And addiction is a disease, or a behavioural disorder if you’re more that way inclined.

Doctors diagnose these disorders/diseases.

And a doctor must know… well… what they know.

So what ***do*** doctors know after their intense medical schooling?

They know what they are taught by the institutions teaching them.

Western Medicine

In the West, the majority of our mental health and addiction specialists know of a variety of mental disorders listed in “The Diagnostic and Statistical Manual of Mental Disorders”.

Mental disorders are listed in the DSM, to help doctors and psychologists correctly diagnose people… and medicate them when necessary.

No. A psychologist is not a doctor.

But I’m sure most of you know that already.

So who gets to decide when it’s necessary to medicate people?

This may be a good time to give you some history on the DSM, some more information on how professionals diagnose mental disorders and what a diagnosis is supposed to be.

And, more interestingly…

how disorders are **created**.

Citations

[1] Barrett, Lisa Feldman (2020). "You Have One Brain (Not Three)". *Seven and a half lessons about the brain*. Boston: Houghton Mifflin Harcourt. pp. 13–28.

[2], [3], [4] Harvard Health Publishing | Harvard Medical School. "**Understanding the stress response"** July 6, 2020

[5] Cannon, Walter (1932). *Wisdom of the Body*. United States: W.W. Norton & Company

References

1. Schmidt, A; Thews, G (1989). "Autonomic Nervous System". In Janig, W (ed.). *Human Physiology* (2 ed.). New York, NY: Springer-Verlag. pp. 333–370.
2. *File:Nervous System diagram-en.svg*. (2016, February 26). Wikimedia Commons. https://commons.wikimedia.org/w/index.php?curid=36395693
3. Cannon, Walter (1932). *Wisdom of the Body*. United States: W.W. Norton & Company. ISBN 978-0393002058.
4. Kwon, Diana. "Fight or Flight May Be in Our Bones". *Scientific American.* Retrieved 2020-06-22.
5. Contributors to Wikimedia projects. (2022, July 22). *Dopamine*. Wikipedia. https://en.wikipedia.org/wiki/Dopamine
6. Berridge KC (April 2007). "The debate over dopamine's role in reward: the case for incentive salience". *Psychopharmacology*. **191** (3): 391–431.

2

The importance of words

Words are important.

I now know there's no such thing as a "mental disorder" because I've taken the time to research the history of the DSM (the Diagnostic and Statistical Manual of Mental Disorders).

So, to be clear, I now know there's no such thing as a mental disorder *in the way in which we currently think of these*.

As in the way the DSM suggests mental health conditions and addictive behaviours to be "disorders". Or the medical profession suggests them to be mental "illnesses".

There are no physical markers or symptoms for these conditions, as there are for a proper illness such as a common cold.

The hypotheses and philosophies of psychology are not hard science or medicine.

They're the opinion of a relatively small demographic of a particular culture. And opinion is regularly skewed by personal perspective, personal bias, personal motivation, politics and, sometimes, financial gain.

At this stage of our understanding, when there's (once again) a strong and more rational move towards a holistic perspective on mental health, this ongoing creation of disorders is badly informed, ethically questionable and outright irresponsible.

But I only understood more about how a disorder is created when I researched the history of the DSM and how it developed into what is now commonly referred to as the "Bible of psychiatry and psychology".

Chapter 2: A History of the Diagnostic and Statistical Manual (Synopsis)

If you are interested in taking a deeper dive, **you can find a full version of this chapter ("The Importance of Words") at the end of this book**.

1. *"The Diagnostic and Statistical Manual of Mental Illnesses is the latest edition of the American Psychiatric Association's professional reference book on mental health and brain-related conditions. Also known as the DSM-5, this is the main guide for mental health providers in the U.S. The latest version, the*

DSM-5-TR, was published in 2022." [7]

2. The rest of the world uses the ICD (International Classification of Diseases) to classify mental health conditions. **The U.S.A also uses the ICD to add codes (related to a "diagnosis" or "disorder") for invoicing so that clients can claim from medical insurances**.

3. The U.S.A played a major role in the development of the ICD and the first edition of the ICD was heavily influenced by a classification system developed by the United States army for categorizing mental health conditions of war veterans after WW2.

4. **War veterans who would have returned home from the war with trauma in the form of PTSD / PTSR (Post Traumatic Stress Disorder / Reaction) and C-PTSD / PTSR (Complex Post Traumatic Stress Disorder / Reaction).**

5. Psychologists and psychiatrists at the time were aware of ***why*** war veterans might be struggling to adjust after the war and chose to take a "psychodynamic" approach when treating people with mental health struggles.

6. "Psychodynamics" looks at how a person's psychology (perception and thinking) impacts their behaviour, feelings and emotions, in relation to external factors and early experience.

7. Lithium was first used in treatment for psychiatric conditions in the 1940s.

8. Pharmaceuticals as a first line of treatment was ***heavily*** encouraged, via advertising and articles, in the American Psychiatric Association's news

publication from the 1950s onwards.

9. The field of psychology and psychiatry in general was not considered scientific or real medicine (1950s to 1980s) and, thus, did not warrant funds being distributed to academic psychiatrists at universities for research grants. There was a move towards a more medical perspective (biological and genetic) by academic psychiatrists, in order to be taken more seriously and to be able to acquire research grants.

10. A task force of nine people was responsible for the third revision of the DSM (1980s), headed by Robert L. Spitzer. Spitzer chose people from an academic/research background (some of whom he had personally collaborated with), with a strongly "biological" (as opposed to "psychodynamic") perspective on the reasons people suffer from mental health conditions as fellow task force members. The majority of whom were American caucasian and male.

11. The word "reactions" was removed from the manual (1980s third revision of the DSM) and the word "disorder" replaced it in full under Spiterzer's guidance. (i.e. depressive "**reaction**" is replaced by depressive "**disorder**" etc. for **all** categories of behaviours in the DSM-III)

12. Only one member of the task force is said to have objected to this change. Dr Pinsker, who came from a psychoanalytic approach.

13. To which Spitzer replied that **reimbursement from medical insurance would be difficult if the classifications were based on sets of symptoms and were not specific** (medical conditions).

14. What behaviours should be considered “Disordered” are decided upon by these small task forces during revisions of the DSM (every 10 years). “Disorders” are voted into (or out of) existence by task force members. Human beings with personal interests, personal connections and, often, personal motivation.

15. In subsequent editions of the DSM problems with the book became more evident, and more public, due to obvious connections between members of the task forces and the pharmaceutical industry. The pharmaceutical industry is a multi billion dollar industry.

16. Many psychiatrists and psychologists have been outspoken with regards to the book and the problems surrounding it.

17. Robert L. Spitzer himself stated some years later, in an interview in 2007, that:

> *the DSM, by operationalizing the definitions of mental disorders* ***while paying little attention to the context in which the symptoms occur*** [my boldface], *may have* ***medicalized the normal human experiences of a significant number of people.*** [my boldface] [8]

18. Jung had real success with the “psychodynamic” approach in 1904. (“An Interesting Story - available in the full version of Ch 2 at the end of this book)

19. All of this is widely known fact and available from reliable resources that share the history and development of the DSM and the ICD. Some of which are on the American Psychiatric Association’s own website.

Update: I discovered, during some final work on this chapter, that a Psychodynamic Diagnostic Manual for use in treatment (the PDM) was endorsed by the American Psychiatric Association in 2006.

Although this still seems to have strong ties to clinical treatments of mental health and addiction (and the more well known DSM), it is based on a more logical and traditional psychoanalytic approach as to uncovering *why* people may be struggling.

Which would, obviously, afford a greater chance for recovery.

A few of the revisions of the DSM

1. Hysteria - once considered to be a problem associated with only women. The word hysteria originates from the Greek word for uterus - Hysteria was finally removed from the DSM as a disorder in **1980**.

2. Autism was originally described as a form of childhood schizophrenia and **the result of cold parenting**, then as a set of related developmental disorders… [38]

3. The terminology used to describe the symptoms of Attention-Deficit Hyperactivity Disorder, or **ADHD**, has gone through many changes over history, including **"minimal brain damage"**, "minimal brain dysfunction", "learning/behavioral disabilities"... [40]

4. Homosexuality was removed from the DSM **as a personality disorder in *1973***; kept in as "ego-dystonic homosexuality" and a variety of other classifications, over the revisions, **until it was removed as "gender identity**

disorder" in 2013… replaced with "gender dysphoria". (yes - it is still listed in the Diagnostic statistical manual of mental disorders in 2022)

It's time we asked "why?" again

What if Sigmund Freud, Carl Jung and other great minds and forerunners of this discovery into the "whys?" of mental health challenges were right all along?

What if these "disorders" are simply reactions to past experience, current external circumstances and an underlying anxiety (neurosis) because of them?

What if, by helping a person process whatever experiences provoke these reactions and teaching them more positive behaviours, these reactions can be minimized or completely eradicated?

What if life has become infinitely more stressful and most households need dual income just to get by?

What if healing primary root causes of these reactions takes time and people can't afford to miss work for long periods?

What if treatment options are expensive and state ones are overwhelmed?

What if private medical insurance only pays for three weeks of treatment and the State can only afford the same duration?

What if treatment facilities only have around three weeks to stabilize people, to get them back to work, and proper recovery and healing for these conditions takes time?

What if the quickest way to get people out of treatment and back to work or school is to diagnose an incurable disorder and medicate them with pharmaceuticals?

And the pharmaceutical industry is one of the most lucrative industries in the world?

What if mental health and addiction have become so stigmatized that most people are afraid to even ask these questions or have this conversation?

What if we've been led to believe that these are medical conditions and doctors know how to treat medical conditions so we should simply trust their judgment?

What if a vast majority of students of psychiatry and psychology are given one book to refer to in treating mental health challenges and are told it is their "Bible of psychiatry and psychology"?

And the remaining students, globally, are also given this book as additional study material during their education?

And what if the majority of mental health professionals and therapists now *also* believe mental health challenges are incurable disorders as a result of this?

I went back to the beginning and took the "Psychodynamic" approach to understanding my trauma induced reactions.

I took a different approach to getting well after I understood what a "diagnosis" was *supposed* to be. And when I began to understand that my (mis)-diagnoses were only a name given to a list of reactions / maladjusted behaviours.

I worked for three tough years to find the root causes of my reactions and focused on recovery for those alone.

I am now four years medication-free with no further support groups, therapists or treatment necessary.

This… when I was repeatedly told, by leading mental health professionals and / or support groups, that I had some kind of disorder (or another), or disease…

and I would need chronic medication or work programs of management for life.

But I only began to make relevant connections to my primary traumas, and progress substantially, when I fully understood what trauma actually is.

And how trauma really “works”.

3

But I don’t have trauma

Many people aren’t aware they have trauma because it’s generally believed to only be the result of a once off life threatening situation.

So let’s talk more about what trauma is and how it works.

What is trauma?

A person is left with trauma from the feeling of being isolated, overwhelmed and unable to manage a situation during a high stress experience. Being traumatized has more to do with how a person perceived and experienced the situation than the incident or situation itself.

This is how some people can be in the exact same situation and one can end up with trauma and one not. In other words, the result of trauma is more dependent on how capable and supported a person felt during the circumstances than the situation itself.

The degree of trauma a person is left with also depends on how capable and/or supported the person felt during the situation.

For example:

Two people are out fishing together.

One person can swim and one can’t.

They’re relatively close to the shoreline when the boat capsizes. They hear a sea gull cry overhead. They see the painted green wooden slats of the bottom of the boat, capsized in the near distance.

The person who can swim laughs at the situation, takes hold of the person who can’t swim and easily helps them to shore.

The person who can't swim remembers to wear a lifejacket or decides to learn to swim before they get back onto a boat again. When they hear a sea gull cry or see a green boat they may remember the incident with some objectivity.

The response of the mind is rational and healthy.

In the second version of the story the one person can't swim and their friend, who can swim, is killed by a shark.

The person who can't swim is left alone, struggling to stay afloat. They see the bloodied water and believe they are about to die as well. They are terrified and overwhelmed.

At this point the mind will disconnect (dissociate) from their emotions and conscious thoughts, so that the person is able to keep moving physically.

In order for them to survive.

In this state of dissociation the struggling person manages to grab onto the green wooden bottom of the capsized boat.

Some hours later, a passing ship rescues them.

But the event is not fully processed by the mind, in this second example, because of the dissociation / disconnect.

This is why the person is left with trauma in the form of Post Traumatic Stress Disorder (PTSD, which I'll refer to as PTSR - Post Traumatic Stress **Reaction** moving forward, in line with the perspective of this conversation).

This is what trauma is.

Trauma is unresolved or mentally “un-processed” events, and information, because of an internal “disconnect” that happens between the mind, the feelings and the external environment associated with the situation…

to facilitate survival.

Trauma recovery focuses on helping a person re-experience the situation in a safe, supported space in order to help the mind process the event properly.

What happens when an event has not been fully processed by the brain due to trauma

Since the mind wasn’t really “conscious”, because of the dissociation, it didn’t have the opportunity to file the information associated with the high stress situation into relevant “folders”. The brain simply lumped *everything* associated with the event into a folder marked “Danger”.

Randomly and unspecifically.

If experiences are processed in a healthy way, the brain will file information into relevant “folders” in the brain, to refer to in the future, that it deems useful for survival. And it’ll discard the information it deems unnecessary over time.

Remembering that this is an oversimplification for illustration purposes.

For this basic explanation, imagine there are different folders in the brain that are marked with category names like:

“Tools”, “Communication” etc. and among these is a folder categorized as “Danger”.

As a person goes through life, and learns, the brain adds things to the different folders for the person to refer to when they’re needed. It adds the things it deems dangerous to the folder marked “Danger” in order to avoid harmful experiences, or to not repeat them, and to keep a person safe.

If a child tries to touch a candle flame and burns their finger, for example, the brain will add “candle”, “fire” and maybe “hot”, “burn”, “don’t touch”, and such things, to the folder categorized as “Danger”.

The child will learn that a candle is not dangerous, but a lit candle is dangerous. If they are introduced to this information consciously.

This happens so the person may avoid getting hurt again and is a part of the natural mechanism of survival mentioned in Chapter One (the Fight / Flight Stress Response).

Our animal instinct to survive.

Let’s return to the above example of the person who is left traumatized by an unprocessed event. The boat capsizing and the shark attack.

Because the brain didn’t have the opportunity to process this event properly, everything that was a part of (or vaguely related to) the situation will simply be dumped into the folder marked “Danger”.

The brain hasn't had a chance to sift through the information properly to "learn" what *was* actually dangerous in the situation.

i.e. That the person was on a boat but couldn't swim and didn't have a life jacket on, for example (dangerous). Or that the red in the water was blood because of the shark bite (sharks can be dangerous but you only find them in the ocean). Or that the cries of seagulls were audible because the person was near the ocean (sea gulls are not dangerous).

But the brain hasn't had the opportunity to do this.

Now, even the cry of a gull, the sound of crashing waves, making red jelly with their child (the red water) or seeing the hull of a green boat will trigger a warning signal in the Amygdala (directly related to the folder marked Danger) that there is an imminent threat in the person's current environment.

Even if there isn't.

To remind you, from Chapter 1, the Amygdala controls the Fight/Flight Stress Reaction when a threat is perceived, to kick the person into the stress response so that they are able to react and find safety.

Now, because the brain has not had the opportunity to sift through the information and the cry of a seagull has been added to the folder marked "Danger", hearing the cry of a seagull in a present situation "triggers" a danger signal in the Amygdala, which sends a signal to the Hippocampus to set off the Fight/Flight Response via the nervous system.

This is not just a mental reaction.

After the brain's reaction, there is also a physical reaction to the "trigger" as the Fight/Flight Stress Response kicks into gear. Heart rate will increase, adrenalin will be released into the body, etc. to enable the person to fight or flee.

This is a "trigger" and a "flashback" and how these work in practice.

Something from an unprocessed event in a person's history incorrectly alerts the brain that there is danger in the present moment.

> *trigger*
>
> *1. n. a stimulus that elicits a reaction. For example, an event could be a trigger for a memory of a past experience and an accompanying state of emotional arousal.*
>
> *2. vb. to act as a trigger.* [9]
>
> *flashback*
> *n.*
>
> 1. *the reliving of a traumatic event … Memories may be triggered by words, sounds, smells, or scenes that are reminiscent of the original trauma (as in a backfiring car triggering a flashback to being in combat).* [9]

What happens, when a person is triggered and is having a flashback, is that there's also a strong sense of being back in the situation.

The perception and thinking of the person change, accordingly, and are often out of sync with the present moment.

It sounds simple, doesn't it?

But **there is more than one type of trauma** and this is where things become a little less obvious and easy to understand.

So let's talk more about the types of trauma and the reasons a person may have them.

Because ~~C-PTSD~~ C-PTSR (**Complex** Post Traumatic ~~Disorder~~ **Reaction**) was only first acknowledged in 1992, if you remember this. (Perfect - Chapter 2: The Importance of Words full version)

What is C-PTSD / C-PTSR?

While Post Traumatic Stress Reaction (PTSD / PTSR) is caused by a once off high stress / life threatening incident (or witnessing or hearing about such an incident), C-PTSR occurs when people are exposed to a threat of harm or injury (micro traumas), **or even a feeling that they are not safe**, over an extended period of time.

The types of trauma that often result in C-PTSR are:

Developmental Trauma, Hereditary Trauma and Multi-generational Trauma. As well as trauma from abusive/dysfunctional relationships (Relational trauma).

Although we like to separate these circumstances, and classify the resultant trauma with different names, they're all the same thing really. The types of trauma listed

above all **happen to people in extended circumstances** (commonly family and relationship environments) and, thus, result in C-PTSR.

So again… for the purposes of this conversation, let's just keep things simple and say it really doesn't matter what *type* of trauma we're talking about, as long as we're aware that there are two main sets of reactions that result from all of them.

The **reactions** of PTSR and C-PTSR.

Since the Amygdala sets off the Fight/Flight Stress Response, when it perceives a threat in the present moment as one of its key roles in the survival mechanism, it's easy to understand how people with PTSR and C-PTSR could be incorrectly triggered into the same Fight/Flight response when they have a "flashback".

When you understand more about *how* trauma works.

Having a "flashback" (i.e. being unexpectedly cast back into the traumatic event emotionally and psychologically, **as well as *actively* being pushed into the Fight/Flight Stress Response because of this**) *will* make people volatile, violent, unpredictable and severely emotionally dysregulated.

If children and loved ones are exposed to these reactions over extended periods of time they will end up with C-PTSR and PTSR as well.

This is how Multi-generational and Hereditary trauma is passed on.

Some people are going to stubbornly insist on the Biological approach, or Disease model, as the reason people have these kinds of reactions and maladjusted behaviours in their attempts to self soothe/find safety again. (These are not attempts to “self medicate” as we like to insist they are).

My answer to the biological/disease perspectives would be this:

Changes in physical structure in the brain are a result of trauma.

Exposure to long term high stress situations impacts the physical structure of the brain (long term exposure to trauma shrinks/enlarges different areas of the brain depending on age).

This may make the brain hypersensitive (or less sensitive) to stress and more (or less) mentally and emotionally **reactive**.

Parents with unresolved PTSR and C-PTSR ***will*** pass this on to the children in the environment via their own reactions, via their traumatized perspectives (e.g. “the world is not safe”) and because of the children’s nervous systems physically synching with the nervous systems of the adults around them.

The children also learn the maladjusted coping mechanisms that their parents may have adopted in order to survive… by rote. Because this is how children learn. **By *instinctively* mimicking the adults around them to win the parents over**. To get the parents to accept and protect them.

In order to survive.

Yes. I am saying that anxiety and depression are both passed on environmentally and also learned by rote. And so is addiction.

Moving back to this conversation, it's easier to understand what I am trying to say by adding the word "abuse" to the conversation.

I hope the word "abuse" doesn't trigger you into leaving this conversation because this is for illustration purposes and most childhood trauma is passed on completely **accidentally** by loving, caring parents.

So stay with me, please, because this is important for you and your children.

The addition of this word is easier to understand if we simply list the behaviours of PTSR and C-PTSR and compare them to behaviours that are considered to be emotionally and psychologically abusive.

But before we do, I quickly want to note the other difference between PTSR and C-PTSR.

PTSR triggers and subsequent flashbacks will be visual, sensory or auditory.

It is quite easy to know where a person with PTSR's disproportionate reactions to the current circumstances may come from.

C-PTSR triggers, however, are barely noticeable and the flashbacks are more "feeling" orientated (commonly called "emotional flashbacks").

The triggers for C-PTSR are *much* harder to see, or understand, because the trauma happened over an extended period of time and was "normalized". This will often leave a person suffering with C-PTSD confused as to *why* they may be reacting strongly at times.

Triggers for C-PTSD flashbacks are so subtle that **a person with C-PTSR will often not know they've been triggered into the Fight/Flight Reaction at all**.

Now let's have a look at PTSR, and C-PTSR and what perspective, reactions and behaviours are exhibited by people suffering with these first.

"SYMPTOMS" OF POST TRAUMATIC STRESS REACTION (PTSR)[10]

1. Recurrent, unwanted distressing memories of the traumatic event
2. Reliving the traumatic event as if it were happening again (flashbacks)
3. Upsetting dreams or nightmares about the traumatic event
4. Severe emotional distress or physical reactions to something that reminds you of the traumatic event
5. Trying to avoid thinking or talking about the traumatic event
6. Avoiding places, activities or people that remind you of the traumatic event
7. Negative thoughts about yourself, other people or the world
8. Hopelessness about the future

9. Memory problems, including not remembering important aspects of the traumatic event
10. Somatic problems - dizziness, nausea, aches and pains
11. Difficulty maintaining close relationships
12. Feeling detached from family and friends
13. Lack of interest in activities you once enjoyed
14. Difficulty experiencing positive emotions
15. Feeling emotionally numb / dissociation
16. Being easily startled or frightened
17. Always being on guard for danger / hyper-vigilance
18. Self-destructive behavior, such as drinking too much or driving too fast
19. Trouble sleeping
20. Trouble concentrating
21. Irritability, angry outbursts or aggressive behavior
22. Overwhelming guilt or shame

    For children (but adults do this as well when they are “acting out" on their trauma and addictions)

23. Re-enacting the traumatic event or aspects of the traumatic event
24. Frightening dreams that may or may not include aspects of the traumatic event [10]

“Symptoms” of COMPLEX-POST TRAUMATIC STRESS (C-PTSR)[11]

People with C-PTSR typically have the above PTSR symptoms along with additional symptoms (“emotional flashbacks” [added by me]), including:

1. **Lack of emotional regulation**

   This refers to having uncontrollable feelings, such as explosive anger or ongoing sadness.

2. **Changes in consciousness**

   This can include forgetting the traumatic event or feeling detached from your emotions or body, which is also called dissociation (derealisation, etc.).

3. **Negative self-perception**

   You may feel guilt or shame, to the point that you feel completely different from other people (every addict in recovery).

4. **Difficulty with relationships**

   You might find yourself avoiding relationships with other people out of mistrust or a feeling of not knowing how to interact with others. On the other hand, some might seek relationships with people who harm them because it feels familiar.

5. **Distorted perception of abuser**

   This includes becoming preoccupied with the relationship between you and your abuser. It can also include preoccupation with revenge or giving your abuser complete power over your life (can include denial about parents' "abusive" behaviour, their personal challenges and the dysfunction in the family system [Added by me]).

6. **Loss of systems of meanings**

   Systems of meaning refer to your religion or beliefs about the world. For example, you might lose faith in some long-held beliefs you had or develop a strong sense of despair or hopelessness about the world. [11]

Simply because of the reactions that people with PTSR and C-PTSR have, and because of how addiction makes people unable to be fully present and capable when relating to other people, **stressed and struggling parents can accidentally traumatize their children**.

Because, as it turns out, the reaction of PTSR and C-PTSR, and the behaviours associated with them, are also listed as the reactions and behaviours that are considered to be the “emotional and psychological abuse” of adults and, specifically, children.

This is usually nobody’s fault and completely unintentional.

When a person is highly stressed, or is having a PTSR or C-PTSR flashback, they are not thinking clearly. They are not “themselves”.

They are acting on “animal instinct” as a result of the Fight/Flight Stress Response. The “reptile brain” has taken over and is driving the person to take action to “survive”.

Please be courageous and be strong now, because this is important.

Let’s have a look at what the experts consider “emotional and psychological abuse” of children to be.

What is Considered Psychological Abuse? [12]

Psychological abuse of a child is often divided into nine categories:

1. **Rejection**: to reject a child, to push him away, to make him feel that he is useless or worthless, to undermine the value of his ideas or feelings, to refuse to help him.

2. **Scorn**: to demean the child, to ridicule him, to humiliate him, to cause him to be ashamed, to criticize the child, to insult him.

3. **Terrorism**: to threaten a child or someone who is dear to him with physical violence, abandonment or death, to threaten to destroy the child's possessions, to place him in chaotic or dangerous situations, to define strict and unreasonable expectations and to threaten him with punishment if he does not comply.

4. **Isolation**: to physically or socially isolate a child, to limit his opportunities to socialize with others.

5. **Corruption or exploitation**: to tolerate or encourage inappropriate or deviant behavior, to expose the child to antisocial role-models, to consider the child as a servant…(I would include forcing a child to take care of, or be responsible for, a struggling parent in this list item [added by me])

6. **The absence of emotional response**: to show oneself as inattentive or indifferent towards the child, to ignore his emotional needs, to avoid visual contact, kisses or verbal communication with him, to never congratulate him.

> **Neglect**: to ignore the health or educational needs of the child, to refuse or to neglect to apply the required treatment. (See: What is Child Neglect?)

7. **Exposure to domestic violence**: to expose a child to violent words and acts between his parents.

The behavior of an emotionally abusive parent or caregiver does not support a child's healthy development and well-being-instead, it creates an environment of fear, hostility, or anxiety. A child is sensitive to the feelings, opinions, and actions of his or her parents.

8. **Showing a lack of regard for the child**

This behavior often includes rejecting the child by:

- Not showing affection.
- Ignoring the child's presence and obvious needs.
- Ignoring the child when he or she is in need of comfort.
- Not calling the child by his or her name.

9. **Saying unkind things to the child**

Emotionally abusive parents say things or convey feelings that can hurt a child deeply. Common examples include:

- Making the child feel unwanted, perhaps by stating or implying that life would be easier without the child. For example, a parent may tell a child, "I wish you were never born."
- Ridiculing or belittling the child, such as saying, "You are stupid."
- Threatening the child with harsh punishment or even death.
- Continuous verbal abuse. [12]

People who are highly stressed or who are having PTSR and C-PTSR flashbacks ***will*** inflict a lot of what is listed above when they are triggered, COMPLETELY UNINTENTIONALLY, upon the people around them.

Interestingly enough, mental and psychological abuse is most commonly noted in families that are:

1. having financial difficulties
2. dealing with single parenthood
3. experiencing (or have experienced) a divorce
4. struggling with substance abuse issues [13]

There are some of what are considered the major life stressors listed here.

So, clearly, even stressed parenting can cause parents to act out “abusively” (unintentionally at times), which is possibly why stressed parenting has been clearly linked to early childhood trauma (Developmental and Relational Trauma).

When you understand how trauma works and look at the reactions of PTSR and C-PTSR, it would be almost impossible for a primary care-giver to remain stable and fully present, or to provide a consistently stable, “safe” environment for a child, if they are suffering from these.

Impossible, really.

A child would often be “neglected” (the impact of which is now known to be ***very*** serious) while a parent with these challenges (or resultant addictions) had sudden, unexpected reactions, mood swings and shifts in perception. And possibly used addictive substances or behaviours in attempts to self soothe.

So even though the reactions and behaviours associated with trauma and its responses aren’t *intentionally* emotionally and psychologically abusive…

they are, in and of themselves, emotionally and psychologically abusive to those exposed to them…

according to the behaviours defined as emotional and psychological abuse.

Symptoms of Child Psychological Abuse [12]

Symptoms of psychological abuse of a child may include:

- Difficulties in school
- Eating disorders, resulting in weight loss or poor weight gain
- Emotional issues such as low self-esteem, depression, and anxiety
- Rebellious behavior
- Sleep disorders
- Vague physical complaints [12]

These look very similar to the “symptoms” of PTSR and C-PTSR, don’t they?

(And ADHD and ADD as well…)

It doesn't really matter what type of trauma it is, is what I'm trying to explain here.

It's the fact that all of these types of trauma, which occur in extended situations or environments in which a child is not **consistently** supported emotionally / psychologically and is unable to extricate themselves from, cause PTSR and C-PTSR in the children in such environments as well.

PTSR and C-PTSR have a multitude and great variety of reactions, and subsequent behaviours, that I strongly believe are being misdiagnosed as some kind of mental illness or another.

Some people may now say that they have been through high stress experiences and their children are fine.

Allow me to clarify at this point, please.

It's not the stressed parenting itself that causes the trauma.

It's HOW the parent handles the stress.

Does the parent understand how trauma is passed on, or created, and know how to manage their own reactions and stay regulated, present and calm for the child?

Is the parent able to explain to the child that they are struggling with stress or unresolved trauma, to apologize if they react inappropriately and to **let the child know that it is not the child's fault**?

Or is the parent still at the mercy of their own unconscious reptile brain, as their trauma/stress triggers them into the Fight/Flight reactions and makes them volatile, unstable and "unsafe" in the child's experience?

Do the parents randomly explode or totally withdraw? Do they get anxious or depressed? Do they turn to alcohol or substances to try and alleviate their reactions? Are they unable to be consistently "present" and available for the child, to support the child in feeling as safe as possible?

Remembering that the child is going through their own development as they grow and attempt to navigate a greatly unknown (and sometimes intimidating) world that is new to them. And is trying to “individuate” successfully while they do this.

A vital time in a human being’s development and when much of the individual’s perception of the world, and *themselves*, is formed.

Regardless of whether it’s intentional or not, the reactions of PTSR and C-PTSR result in behaviours that **are** similar, or identical, to behaviours that **are** considered to be emotional and psychological abuse.

And the result of a child (or adult) being exposed to these reactions and behaviours, over time, will be trauma in the form of PTSR and C-PTSR as well. With the same reactions. And the same, or similar, addictive behaviours in attempts to self soothe.

If you combine this with the fact that children internalize their parents' bad moods or personal challenges (a well known fact in psychology), the adult child will be left, possibly permanently, with the belief that there is something inherently “wrong” with them. That they “are not good enough”. That they are “worthless”. Or that they are, somehow, “different” to most people.

As adults, with C-PTSR, they may have a simple conversation, with someone seemingly random, and suddenly have a panic attack or sink into “depression”. (The “Freeze” response)

This is because the “emotional flashbacks” of C-PTSR have very subtle triggers and are very difficult to pinpoint. Most people with C-PTSR will not even know why they are being triggered. Or when they are being triggered.

They may even believe they have a mental “illness” or “disorder” because their mental and emotional dysregulation **seems** so irrational.

And medical doctors tell them they have a “disorder” of some kind.

My reactions were completely rational and quite beautifully logical when I understood things better.

My so-called “symptoms” of the many misdiagnosed mental “disorders” were all emotional flashbacks from my C-PTSR.

The C-PTSR reactions of the fight/flight Stress Response that I found to be correct, for me personally, were:

- Fight : angry outbursts / anti-social behaviour
- Flight : anxiety / dissociation / derealization
- Fawn : codependency
- Freeze : depression

I was going to share case studies and examples to show you how this works in action and how addiction is a reasonable, rational response to being triggered as well.

I don't, however, want to over complicate things.

This is more than enough, with the history in Chapter 2, to give people information on why they may want to **focus on trauma recovery** before they believe they have some kind of "disorder".

I'm also physically unwell and need to streamline for health reasons now.

My current challenges are largely due to the fact that some highly respected professionals were unable to see what was right in front of them and caused far more harm than healing.

But this story is not uncommon.

The majority of mental health professionals have been given one book to refer to as "the bible of psychiatry and psychology" to "diagnose" "patients", you see.

The Diagnostic Statistical Manual of Mental Disorders.

Developed off the back of a hospital administrative manual that was never meant to be a guide to treating people.

With a biological perspective on the causes of mental health conditions that encouraged pretty barbaric and dangerously radical physical interventions as treatments.

Off the back of a government census that relied on census officials, heads of families and slave owners to decide who was or was not sane.

As a variant of WHO's manual of International Disease Classifications, which was heavily influenced by mental health classifications by the U.S military service of its war veterans.

With the word "reactions" removed in the third revision and replaced with the word "disorders", by only nine people of mostly one demographic, because (by the leader of the task force's own admission) "**reimbursement from medical insurance would be difficult if the classifications were based on sets of symptoms and were not specific" (to medical conditions)**.

Which would also protect the personal interests of professionals treating these conditions by making them more affordable to clients.

Which would encourage pharmaceutical medicines as being a first line of treatment.

By a task force of mostly academic psychiatrists who originally had a personal interest in medicalising mental health conditions, as they could not get funding for research because psychology was not considered "scientific" enough to warrant this.

With future task force members having well known and very public ties to the pharmaceutical industry.

No, I am not a "conspiracy theorist".

All of this is factual, and included in the history of the DSM, available from reliable sources to anyone who is curious enough to ask “how?” and “why?”.

Please feel free to ask questions in the comments. I’ll gladly answer them as best I can and add links for you to access the information I found as time allows.

And please remember that there is (in all probability) nothing “wrong” with you or your children.

Because have a look at this:

PTSR & C-PTSR REACTIONS	BORDERLINE PERSONALITY REACTIONS [13]
PTSR & C-PTSR “flashbacks” C-PTSR flashbacks will not be recognisable “memories”. A person with C-PTSR may suddenly feel anxious or depressed and not know why. Or they may not even realize that they are anxious because C-PTSR happens over an extended period of time and is “normalized” The word “memories” in the items listed below can be visual and/or emotional. 1. Recurrent, unwanted distressing memories of the traumatic event 2. Reliving the traumatic event as if it were happening again (flashbacks) 3. Upsetting dreams or nightmares about the traumatic event 4. Severe emotional distress or physical reactions to something that reminds you of the traumatic event	The “symptoms” of Borderline Personality “Disorder”. A different “disorder” from the Diagnostic and statistical manual of mental disorders: DSM-5™, 5th ed to PTSR and C-PTSR. Let’s see how many of these “symptoms” are the same… DSM-IV states that Borderline Personality Disorder (BPD) is: “A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:” Which would be a logical result of being triggered but not understanding why (C-PTSD) because Complex Post Traumatic stress is not “visible” or obvious

5. Trying to avoid thinking or talking about the traumatic event 6. Avoiding places, activities or people that remind you of the traumatic event	
Which would result in: 7. Negative thoughts about yourself, other people or the world 8. Difficulty maintaining close relationships 9. Distorted perception of abuser 10. Feeling detached from family and friends 11. Difficulty with relationships 12. Feeling emotionally numb / dissociation 13. Memory problems, including not remembering important aspects of the traumatic event 14. Trouble sleeping (leads to psychosis added by me) 15. Trouble concentrating 16. Changes in consciousness 17. Lack of emotional regulation 18. Being easily startled or frightened 19. Always being on guard for danger / hyper-vigilance	1. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation 2. Transient, stress-related paranoid ideation or severe dissociative symptoms 3. Affective instability due to a marked reactivity of mood 4. irritability, or anxiety usually lasting a few hours and only rarely more than a few days

20. Irritability, angry outbursts or aggressive behavior	5. Inappropriate, intense anger or difficulty controlling anger 6. temper, constant anger, recurrent physical fights)
21. Negative self-perception 22. Loss of systems of meanings 23. Overwhelming guilt or shame (**primary symptoms of trauma**)	7. Identity disturbance: markedly and persistently unstable self-image or sense of self.
Which may logically result in:	
24. Lack of interest in activities you once enjoyed 25. Hopelessness about the future 26. Difficulty experiencing positive emotions	8. Chronic feelings of emptiness Which may logically result in:
Which someone may try to avoid by:	9. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
27. Self-destructive behavior, such as drinking too much or driving too fast	10. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex,) 11. substance abuse, reckless driving, binge eating).

	I see many therapists claiming that Borderline personality “Disorder” is different to C-PTSD, even though the symptoms are similar because of this last reaction: 12. Frantic efforts to avoid real or imagined abandonment This could simply be due to a person displaying this reaction having an “anxious” attachment style. (**John Bowlby’s Attachment Theory**) Reactions listed from source [14]
Unaddressed trauma and mood affects the way a person sits and moves over time (e.g. muscle armouring because of constant high alert/backache because of slouching due to sadness), which results in: 28. Somatic problems - dizziness, nausea, aches and pains	

PTSR & C-PTSR REACTIONS	ADHD & ADD REACTIONS [14]
PTSR & C-PTSR “flashbacks” C-PTSR flashbacks will not be recognisable “memories”. A person with C-PTSR may suddenly feel anxious or depressed and not know why. Or they may not even realize that they are anxious because C-PTSR happens over an extended period of time and is “normalized” The word “memories” in the items listed below can be visual and/or emotional.	Difficulty concentrating is a part of “anxiety” and “depression” which are part of the Fight/Flight reactions of C-PTSD (Fight/Flight and Freeze) An adult may suffer from the same “symptoms” listed under the reactions for ADHD and ADD if they are suffering from PTSR & C-PTSR. List of behaviours: [15]
1. Memory problems, including not remembering important aspects of the traumatic event 2. Trouble concentrating	**Inattentiveness (difficulty concentrating and focusing)** The main signs of inattentiveness are: 1. appearing forgetful or losing things 2. having a short attention span and being easily distracted

3. Changes in consciousness When PTSR and C-PTSR are “triggered” and a person goes into the Fight/Flight reaction, they will have trouble concentrating and staying still (unless the response they go into is the “Freeze” reaction - usually when Fight or Flight is unsuccessful) To be more clear, “Anxiety” is the “Flight” reaction for C-PTSD and **it is extremely difficult to concentrate, remember things or stay still in this state.** Or even to think clearly. 4. Lack of emotional regulation 5. Trying to avoid thinking or talking about the traumatic event	3. making careless mistakes – for example, in schoolwork 4. being unable to stick to tasks that are tedious or time-consuming 5. appearing to be unable to listen to or carry out instructions 6. constantly changing activity or task 7. having difficulty organizing tasks **Hyperactivity and impulsiveness** The main signs of hyperactivity and impulsiveness are: being unable to sit still, especially in calm or quiet surroundings 1. constantly fidgeting 2. being unable to concentrate on tasks 3. excessive physical movement

6. Always being on guard for danger / hyper-vigilance	4. excessive talking 5. being unable to wait their turn 6. acting without thinking 7. interrupting conversations
7. Being easily startled or frightened 8. Irritability, angry outbursts or aggressive behaviour	
9. Self-destructive behavior, such as drinking too much or driving too fast	8. little or no sense of danger
10. Feeling emotionally numb / dissociation 11. Feeling detached from family and friends 12. Difficulty maintaining close relationships 13. Difficulty with relationships 14. Negative thoughts about yourself, other people or the world 15. Negative self-perception 16. Overwhelming guilt or shame 17. Difficulty experiencing positive emotions 18. Lack of interest in activities you once enjoyed 19. Loss of systems of meanings 20. Hopelessness about the future	
21. Distorted perception of abuser 22. Trouble sleeping	
Unaddressed trauma and mood affects	

the way a person sits and moves over time (e.g. muscle armouring because of constant high alert/backache because of slouching due to sadness), which results in: 23. Somatic problems - dizziness, nausea, aches and pains	

PTSR & C-PTSR REACTIONS	AUTISM REACTIONS [15]
	List of reactions: [15]
1. Recurrent, unwanted distressing memories of the traumatic event 2. Reliving the traumatic event as if it were happening again (flashbacks) 3. Upsetting dreams or nightmares about the traumatic event 4. Severe emotional distress or physical reactions to something that reminds you of the traumatic event 5. Trying to avoid thinking or talking about the traumatic event 6. Avoiding places, activities or people that remind you of the traumatic event Which would result in: 7. Feeling emotionally numb / dissociation 8. Feeling detached from family and friends 9. Difficulty maintaining close relationships 10. Difficulty with relationships 11. Changes in consciousness 12. Trouble concentrating	**YOUNG CHILDREN / OLDER CHILDREN** [16] 1. not responding to their name 2. avoiding eye contact 3. not talking as much as other children 4. not smiling when you smile at them 5. not seeming to understand what others are thinking or feeling

13. Negative thoughts about yourself, other people or the world 14. Negative self-perception 15. Overwhelming guilt or shame 16. Memory problems, including not remembering important aspects of the traumatic event 17. Lack of interest in activities you once enjoyed 18. Loss of systems of meanings 19. Hopelessness about the future 20. Difficulty experiencing positive emotions 21. Lack of emotional regulation 22. Being easily startled or frightened 23. Always being on guard for danger / hyper-vigilance 24. Irritability, angry outbursts or aggressive behavior	6. finding it hard to make friends or preferring to be on their own 7. finding it hard to say how they feel *(codependency - fawn reaction?)* 8. taking things very literally – for example, they may not understand phrases like "break a leg" 9. not doing as much pretend play 10. "Depression" *(Comorbid)* 11. getting very upset if they do not like a certain taste, smell or sound 12. unusual speech, such as repeating phrases and talking 'at' others 13. liking a strict daily routine and getting very upset if it changes *(could be attempts to avoid being startled or surprised / anxiety / hypervigilance?)* 14. getting very upset if you ask them to do something 15. "Anxiety *(Comorbid)*

25. Distorted perception of abuser 26. Trouble sleeping 27. Self-destructive behavior, such as drinking too much or driving too fast Unaddressed trauma and mood affects the way a person sits and moves over time (e.g. muscle armouring because of constant high alert/backache because of slouching due to sadness), which results in: 28. Somatic problems - dizziness, nausea, aches and pains	16. repetitive movements, such as flapping their hands, flicking their fingers or rocking their body *(could behavioural addictions to self soothe?)* 17. repeating the same phrases *(could behavioural addictions to self soothe?)* 18. having a very keen interest in certain subjects or activities *(could behavioural addictions to self soothe - gaming addiction has this "symptom"?)*

PTSR & C-PTSR REACTIONS	BIPOLAR REACTIONS [16]
PTSR & C-PTSR “flashbacks” **C-PTSR flashbacks will not be recognisable “memories”.** A person with C-PTSR may suddenly feel anxious or depressed and not know why. Or they may not even realize that they are anxious because C-PTSR happens over an extended period of time and is “normalized” The word “memories” in the items listed below can be visual and/or emotional.	The American Psychiatric Association states: “Bipolar disorder is a **brain disorder** that causes changes in a person's mood, energy, and ability to function. People with bipolar disorder experience intense emotional states that typically occur during distinct periods of days to weeks, called mood episodes. These mood episodes are categorized as manic/hypomanic (abnormally happy or irritable mood) or depressive (sad mood). “ The “symptoms” of BiPolar “Disorder” are listed below. [17] Let’s see how many of these “symptoms” are the same as PTSD and C-PTSD.
1. Recurrent, unwanted distressing memories of the traumatic event 2. Reliving the traumatic event as if it were happening again (flashbacks) 3. Upsetting dreams or nightmares about the traumatic event 4. Severe emotional distress or physical reactions to something that reminds you of the traumatic event	

5. Trying to avoid thinking or talking about the traumatic event 6. Avoiding places, activities or people that remind you of the traumatic event 7. Memory problems, **including not remembering important aspects of the traumatic event**	
Which would result in:	**MANIC EPISODE**
8. Being easily startled or frightened 9. Always being on guard for danger / hyper-vigilance 10. Lack of emotional regulation 11. Irritability, angry outbursts or aggressive behavior	1. Increased or faster speech **(Same as anxiety - Fight/Flight)** 2. Uncontrollable racing thoughts or quickly changing ideas or topics when speaking **(Same as anxiety - Fight/Flight)**
12. Trouble sleeping	3. Decreased need for sleep (e.g., feeling energetic despite significantly less sleep than usual
13. Trouble concentrating	4. Distractibility 5. Difficulty concentrating *(Flight reaction again - "anxiety"?)* 6. Increased activity (e.g., restlessness, working on several projects at once) Could be a behavioural addiction, work addiction, in attempts to self soothe

14. Self-destructive behavior, such as drinking too much or driving too fast	7. Increased risky behavior (e.g., reckless driving, spending sprees) 8. Increased or decreased appetite (Disordered eating / could be linked to addiction and high risk behaviour or "acting" out to self soothe if there is disordered eating in the family) **DEPRESSIVE EPISODE**
15. Feeling emotionally numb / dissociation 16. Hopelessness about the future 17. Loss of systems of meanings **18. Negative self-perception** 19. **Overwhelming guilt or shame** (**primary symptoms of trauma**) 20. Lack of interest in activities you once enjoyed 21. Difficulty experiencing positive emotions 22. Negative thoughts about yourself, other people or the world	9. Intense sadness or despair 10. Loss of interest in activities the person once enjoyed **11. Feelings of worthlessness or guilt** 12. Fatigue *(Freeze reaction / "Depression"?)* 13. Increased or decreased sleep *(Flight/Freeze reactions of C-PTSD - "anxiety/"depression"?)*
23. Feeling detached from family and friends 24. Difficulty maintaining close relationships 25. Difficulty with relationships **Anyone** with a (so-called) "Personality Disorder"	These are the more severe BiPolar reactions (BiPolar I) and may simply be PTSD and C-PTSD reactions - extended for the set duration required for a "diagnosis" because the person is in an environment that is triggering them for an extended period of time. I.e. due to

	constant exposure to the cause of their distress. Which may logically result in: 14. Frequent thoughts of death or suicide Specifically if a person is unable to extricate themselves from the circumstances and does not understand what is happening to them.
26. Changes in consciousness	15. Restlessness (e.g., pacing) or slowed speech or movement 16. Can be psychotic episodes *(see Bateson's Double Bind Theory)*
27. Distorted perception of abuser Unaddressed trauma and mood affects the way a person sits and moves over time (e.g. muscle armouring because of constant high alert/backache because of slouching due to sadness), which results in:	Many people with C-PTSD will not be aware that dysfunctional environments have caused (or are causing) them distress
28. Somatic problems - dizziness, nausea, aches and pains	

PTSR & C-PTSR REACTIONS	SCHIZOPHRENIA REACTIONS [17]
PTSR & C-PTSR “flashbacks” C-PTSR flashbacks will not be recognisable “memories”. A person with C-PTSR may suddenly feel anxious or depressed and not know why. Or they may not even realize that they are anxious because C-PTSR happens over an extended period of time and is “normalized” The word “memories” in the items listed below can be visual and/or emotional.	The American Psychiatric Website states that Schizophrenia is: “Schizophrenia is a **chronic brain disorder** that affects less than one percent of the U.S. population. **When schizophrenia is active**, symptoms can include delusions, hallucinations, disorganized speech, trouble with thinking and lack of motivation.” I wonder how a “chronic brain disorder” could be “active” or inactive? I know people, however, do ***react*** to stimuli. Below I have listed the “symptoms” of Schizophrenia. Let’s see how many of these “symptoms” are the same… [18]
1. Recurrent, unwanted distressing memories of the traumatic event	I ***know*** that being “stuck” in a triggering environment for an extended period of time, combined with inadequate nutrition and lack of sleep results in severe Fight/Flight reactions and, eventually, psychosis **if a person is**

2. Reliving the traumatic event as if it were happening again (flashbacks) 3. Upsetting dreams or nightmares about the traumatic event 4. Severe emotional distress or physical reactions to something that reminds you of the traumatic event 5. Trying to avoid thinking or talking about the traumatic event 6. Avoiding places, activities or people that remind you of the traumatic event Which would result in: 7. Negative thoughts about yourself, other people or the world 8. Difficulty maintaining close relationships 9. Distorted perception of abuser 10. Feeling detached from family and friends 11. Difficulty with relationships 12. Memory problems, including not remembering important aspects of the traumatic event 13. Trouble sleeping	**unaware that the situation is causing them harm** (C-PTSD - Developmental & Relational Trauma) The person pushed into a psychosis may “not be allowed” to acknowledge or react to the situation and will be unable to extricate themselves from the situation causing it. The neglect and/or abuse, and the trauma being inflicted, will be “hidden” and the person’s reality will go unvalidated. The “cognitive dissonance” can cause the mind to “split” into “psychosis”. Bateson’s Double bind Theory 1. … paranoia and exaggerated or distorted perceptions, beliefs and behaviors.

14. Trouble concentrating 15. Changes in consciousness 16. Negative self-perception 17. Loss of systems of meanings 18. Lack of emotional regulation 19. Being easily startled or frightened 20. Always being on guard for danger / hyper-vigilance 21. Irritability, angry outbursts or aggressive behavior 22. Feeling emotionally numb / dissociation 23. Lack of interest in activities you once enjoyed 24. Hopelessness about the future 25. Difficulty experiencing positive emotions 26. Overwhelming guilt or shame 27. Self-destructive behavior, such as drinking too much or driving too fast	2. Hallucinations, such as hearing voices or seeing things that do not exist, paranoia and exaggerated or distorted perceptions, beliefs and behaviors. 3. A loss or a decrease in the ability to initiate plans, speak, express emotion or find pleasure. 4. Confused and disordered thinking and speech, trouble with logical thinking and sometimes bizarre behavior or abnormal movements 5. A loss or a decrease in the ability to initiate plans, speak, express emotion or find pleasure.

Unaddressed trauma and mood affects the way a person sits and moves over time (e.g. muscle armouring because of constant high alert/backache because of slouching due to sadness), which results in: 28. Somatic problems - dizziness, nausea, aches and pains	

One might apply this formula to any “disorder” listed in the DSM.

All of the “disorders” in the DSM seem to have reactions and behaviours that coincide with, and overlap, each other.

Some of you may think that the “disorders” listed in the DSM don’t have all the reactions of PTSR and C-PTSR, so they can’t be these.

I’d reply that not everyone has all of the symptoms of a real illness, such as influenza, either. And everybody has varying degrees of it, when they do have it, depending on their physical health and environment.

All of these mental health challenges and behaviours may well be the exact same thing, playing out in different ways, dependent on past experiences, current circumstances and environmental triggers. As well as dysfunctional family roles and the resultant behaviours that are adopted accordingly. And the attachment styles of individuals.

If one looks at this from the perspective that a human being’s reactions to their environment are rationally motivated by survival, that is.

Survival in the sense that a stress response to a perceived threat in an environment will kick off the Fight/Flight mechanism.

And this will naturally result in an inability to focus, to remember things, to concentrate, to engage socially or even to sit still at times. And may cause individuals to act out in unusual and anti-social ways.

If the person is unable to fight or flee, the stress reaction may then move into fawn or freeze (depression). Mentioned way back in the 50's by doctors who already knew best!

The description in the DSM-I for the main Psychoneurotic **reactions** category read:

> *"The chief characteristic of these disorders is "anxiety" which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (depression, conversion, displacement, etc.)* (DSM-I, American Psychiatric Association, 1950)
>
> *…"Anxiety" in psychoneurotic disorders* ***is a danger signal felt and perceived by the conscious portion of the personality****…* (DSM-I, American Psychiatric Association, 1950).
>
> *It is produced by a threat from within the personality (e.g.,* ***by supercharged repressed emotions*** [my boldface], *including such aggressive impulses as hostility and resentment), with or without stimulation from such external situations as loss of love, loss of prestige, or threat of injury."* (DSM-I, American Psychiatric Association, 1950)

Doctors around the 50's already knew **what** they should be treating to successfully help people with mental health challenges.

And addictions may simply be behaviours that are adopted in attempts to self soothe and find safety. Learned coping mechanisms from the family dysfunction, from primary caregivers, by rote.

As mine were.

Addictions should never, in my experience, have been considered “disorders” or some kind of “disease” in and of themselves.

The more serious categories of reactions, such as BiPolar and Schizophrenia, were much the same for me. Only far more intense because I was still in an environment that was a threat to me emotionally and psychologically **even though I wasn’t fully conscious of this**.

The cognitive dissonance between my “instinct” (the Amygdala) and my learned social dynamics eventually drove me into a psychosis.

Gregory Bateson has written a paper on this called “The Double Bind Theory”.

His theory explains *exactly* what my psychosis was.

By the time I took myself in to see a medical professional, in my late twenties, I was having full blown auditory hallucinations, was pretty delusional and I could barely leave my home. My reactions were that severe.

This was due to ongoing exposure to a major trigger, from a primary trauma, in an environment from which I was unable to extricate myself. I was also being told nothing was happening and I was imagining things. i.e. my “reality” was not being validated.

Interestingly enough, this almost happened again in my late forties…

when I was back in an almost identical situation with the same triggers for an extended period of time. And my reality was not being validated. Again.

This was my biggest clue as to what some of my mental health challenges actually were.

Environment is *crucial* when one is looking at lasting recovery for mental health and addiction.

If we are looking at psychosis from the perspective of Bateson's theory and the great forerunners of psychoanalysis as well.

The mind eventually "splits" in order to avoid the "truth" of some situations and "delusions" or "hallucinations" are the unconscious trying to bring things to light in a lateral, and therefore less threatening, way.

In this way, the person may be able to acknowledge the situation more "safely". Yet another attempt, by the unconscious, to encourage the person to take action in order to move them into safety and/or heal them.

In order to survive.

The DSM offers guidelines on the duration of these reactions being present, in order for a "diagnosis" to be made. Various reactions for various "disorders" must be present for a set duration of time in order for them to be considered a "disorder".

But if a person is permanently in an environment that the reptile brain perceives to be a threat, this may be the reason that some people's reactions are ongoing. Or go as far as a psychosis.

It may all be far more simple than we've been led to believe it is.

Because medical insurance companies will not pay out for things that are not classified medical illnesses. Which is exactly why the word “disorder” was added to the Diagnostic and Statistical Manual of Mental Disorders in the third revision in the 1980’s.

By the admission of the leader of the task force, Dr Robert Spitzer, himself.

What a sad state of affairs we find ourselves in when, it seems, **the early psychiatrists and psychologists had already found the correct treatment for these challenges way back in the 1950s**.

Current practice and treatment failings

1. Current standard practice of diagnosing people with **incurable** chronic medical “**disorders**” prevents recovery.

2. Current practice further traumatises individuals due to lack of validation, social stigma and further isolating them (which ***causes*** trauma) by labeling them as “disordered”, “diseased” or “ill” because of their thoughts, feelings and reactions.

   Validation of an individual’s experience is, arguably, ***the*** single most vital component in trauma recovery (as is ***trust*** in the professional guiding it).

3. Current practice does not address the underlying cause of the reactions.

4. Prescribing pharmaceutical medications for “disorders” for lifetimes, often with unpleasant side effects which require even more medications, only alleviates the symptoms of the underlying causes and prevents proper recovery.

5. Telling an “addict” or a “mentally ill” person (in treatment and support groups, no less) that they are “diseased” or “disordered” and need to make amends to, or read letters of consequences from other family members who are a part of and also responsible for the family dysfunction, in a public group setting, is emotionally and psychologically abusive.

   In dysfunctional families and the roles assigned, there will usually be a “scapegoat” or “identified patient” in the family who is unconsciously assigned the role of carrying the family “insanity” (trauma) and dysfunction (denial). Denying family dysfunction and blaming one individual is “gaslighting” and is, again, listed as emotional and psychological abuse.

   Blaming one individual also assists the dysfunctional system in keeping the trauma buried through denial and by avoiding accountability. This will prevent recovery for both the individual and the system itself. And probably traumatize future generations through hereditary and multi-generational trauma.

6. The same issue applies to families/people who are suffering and society at large. By stigmatizing these challenges as “diseases” and “disorders” blame is apportioned to the individual or family and not the failings and stressors of a society.

7. One 45 minute session is not adequate for a proper background history or any kind of authentic psychoanalytic process. Yet people are now being diagnosed

with disorders and prescribed chronic psychiatric medication for life times as standard practice in the first 45 minute session with professionals.

8. Three weeks is not enough time to help anyone “recover” from an addiction or mental health crisis. But three weeks of treatment is all medical insurance will cover and pharmaceutical medications are the fastest way to stabilize people, resulting in an overprescription of medications.

9. Psychology and psychiatry are ***not*** hard science or medicine. They are opinion.

10. What seems “normal” to one person in one country may seem abnormal to another person from another country, culture, gender, age group, ethnic group.

    Yet, worldwide, we now believe we, or our loved ones, are sane or “disordered”/insane because of the ***opinion*** of one small demographic from one country in the world.

    That ***is*** fucking insane! (Sorry, Alan…a sweary word sneaked in while you were away)

My apologies if this isn’t as professional and succinct as I’d like it to be, by the way. The editor on this project fell ill (properly physically ill) and had to step back.

And I’m not a medical doctor or a psychologist.

I’m just a Schizophrenic, BiPolar, Borderline, Anxiety & Depression Disordered Addict who is, somehow sitting writing this today, five years medication free with no further treatment necessary.

Citations

[7] *DSM-5: What it is & what it diagnoses*. (n.d.). Cleveland Clinic. Retrieved February 16, 2023, from https://my.clevelandclinic.org/health/articles/24291-diagnostic-and-statistical-manual-dsm-5

[8] Contributors to Wikimedia projects. (2022d, October 7). Robert spitzer (psychiatrist). Wikipedia. https://en.wikipedia.org/wiki/Robert_Spitzer_(psychiatrist

[9] *APA Dictionary of Psychology*. (n.d.). Retrieved February 16, 2023, from https://dictionary.apa.org/

[10] *Post-traumatic stress disorder (PTSD) - Symptoms and causes*. (2022, December 13). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967

[11] Gilles, G. (2018, January 26). *Understanding complex post-traumatic stress disorder*. Healthline Media. https://www.healthline.com/health/cptsd#symptoms

[12] *What is Psychological Abuse of a Child?* (n.d.). HealthyPlace. Retrieved February 15, 2023, from https://www.healthyplace.com/abuse/child-psychological-abuse/what-is-psychological-abuse-of-a-child

[13] Carey, E. (2018, May 30). *Child emotional and psychological abuse*. Healthline Media. https://www.healthline.com/health/child-neglect-and-psychological-abuse

[14] *Borderline personality disorder - DSM -5 and ICD -11 diagnostic criteria*. (2021, December 14). Psych Scene Hub. https://psychscenehub.com/psychpedia/borderline-personality-disorder-dsm-5-and-icd-11-diagnostic-criteria/

[15] website, N. (n.d.-a). *Signs of autism in children*. Nhs.Uk. Retrieved February 16, 2023, from https://www.nhs.uk/conditions/autism/signs/children/

[16] *What are bipolar disorders?* (n.d.). What Are Bipolar Disorders? Retrieved February 16, 2023, from https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders

[17] *What is Schizophrenia?* (n.d.). What Is Schizophrenia? Retrieved February 16, 2023, from https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia

References

1. Gupta, S. (2022, June 21). What is psychological abuse? *Verywell Mind*. https://www.verywellmind.com/psychological-abuse-types-impact-and-coping-strategies-53231

75

2. NSPCC. (n.d.). *Emotional abuse*. NSPCC. Retrieved February 15, 2023, from https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/emotional-abuse/#what)
3. *Post-traumatic stress disorder (PTSD) - Symptoms and causes*. (2022, December 13). Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967
4. website, N. (n.d.). *Signs of autism in children*. Nhs.Uk. Retrieved February 16, 2023, from https://www.nhs.uk/conditions/autism/signs/children/

2

THE IMPORTANCE OF WORDS

Words are important.

I now know there's no such thing as a "mental disorder" because I've taken the time to research the history of the DSM (the Diagnostic and Statistical Manual of Mental Disorders).

So, to be clear, I now know there's no such thing as a mental disorder *in the way in which we currently think of these*.

The way in which we've been led to think of these because the DSM refers to mental reactions and addictive behaviours as "disorders". And a majority of the medical profession also refers to them as "illnesses" or "diseases".

There are no physical markers or symptoms for these conditions, as there are for a proper illness such as a common cold.

The hypotheses and philosophies of psychology are not hard science or medicine.

They’re the opinion of a relatively small demographic of a particular culture. And opinion is regularly skewed by personal perspective, personal motivation and, sometimes, financial gain.

At this stage of our understanding, when there’s (once again) a strong and more rational move towards a holistic perspective on mental health, this ongoing creation of disorders is badly informed, irresponsible and ethically questionable.

But I only understood more about how a disorder is **created** when I researched the history of the DSM and how it developed into what is now commonly referred to as “the bible of psychiatry and psychology”.

I’ve chosen to cite information from credible sources in this chapter because this information is extremely important. Without understanding what a mental diagnosis is, the majority of people who may receive one will probably never be able to get well.

I also know, from past experience, that my authority and knowledge in this arena will be questioned (or ignored) because I’m not a doctor or psychologist.

Everything I’m about to share with you is historical fact, some of it quoted from The American Psychiatric Association’s own website articles and archives. Some interesting connections become apparent, when the development of the DSM is looked at in chronological order.

Although this proverbial rabbit hole goes even deeper when one begins to examine the background history of some of the individuals involved, and hence understands more about what their underlying personal motivation may have been, the information included should be more than enough to offer people some insight into why they may not be "disordered" at all.

I’ve added explanations below the citations for those who may be put off by the psychological jargon. And, in accordance with standard practice throughout, I’ve made specific bits of information bold for you to take note of.

Like this.

It’s an interesting story and worth reading if you, or those close to you, may prefer a more rational and lasting solution for mental health and addiction challenges. Professions seem to add enough jargon to confuse lay people in order to maintain positions of unquestionable authority.

You are intelligent and capable enough to become informed and to make better informed decisions for your health. This professional arena, particularly, has overly complicated things. And possibly done this intentionally.

Please take the time to read and consider this chapter thoroughly. I’ve tried to keep it as light and entertaining as possible despite the very serious nature of the content it contains.

The History of the DSM

We tend to think of people like Freud and Jung as the "fathers of psychology". Yet the history of the “the bible of psychology and psychiatry” (the DSM), which impacts how psychological conditions are viewed and treated on a global scale today, begins in 19th Century America.

And there with the Constitutionally mandated census of 1840.

The 1840 US Census

> *What might be considered the first official attempt to gather information about mental health in the United States was the recording of the frequency of “idiocy/insanity” in the 1840 (U.S. government) census.*[1]
>
> *The Census Bureau added the question at a time when reformers were interested in creating institutions to help people with mental disabilities.*[2]

The 1840 census asked each head of family a variety of questions, but the only ones pertinent to this conversation are:

- *The number of free White males and females, respectively: (list of ages)*
- *The number of slaves and free Colored persons of each sex, respectively: (list of ages)*
- *The number of White persons who were insane and idiots (at public and private charge)*
- *The number of Colored persons who were insane and idiots (at public and private charge).*[3]

Insanity or idiocy were decided upon by heads of family and census officials. Not mental health professionals. This resulted in slave owners deciding upon the sanity or idiocy of their slaves, for example.

A mental health diagnosis based on the opinion of a slave owner, skewed by personal perspective, personal motivation and, definitely, financial gain.

> *Slavery was good for Black people, the figures indicated, and freedom led to insanity.*[4]
>
> *Specifically, free Black people were far more likely than the enslaved to succumb to insanity. "Insanity and idiocy" was ten times more common among free Black people than among those who were slaves.*[4]
>
> *What else could this mean, advocates of slavery asked, but that Black people were mentally unsuited for freedom?* [4]

The use of diagnosing people as sane or insane for political reasons and financial gain is immediately obvious. As is the danger of one demographic's *opinion,* defining what "sane" or "insane" is.

Regardless of these concerns the government continued to ask these questions in the 1880 U.S. Census.

The 1880 US Census

> *By the 1880 census, seven categories of mental health were distinguished: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy.*[5]

There are two main categories of mental health conditions at this point:

1. Psychological reactions: elevated mood, activity and thinking (mania); depression (melancholia); addictive behaviours (monomania); alcoholism (dipsomania).

2. And physical abnormalities of the brain: epilepsy; dementia; paresis (originally thought to be a result of syphilis, which *is* physically disease related).

The physical category has structural abnormalities, or disease. The other conditions do not have physical markers of disease or biological abnormalities.

The psychological categories in the 1880 census do not indicate physical markers of illness or disease because they are not diseases or disorders in the way in which we've been led to believe they are today.

By this time there was also a growing awareness of cost to State of inpatients in institutions, an ongoing interest in eugenics and some pretty discriminatory personal perspective clouding the air.

> *Eugenicists theorized that behaviors like criminality and prostitution were products of mental instability, and therefore inheritable traits that "feeble-minded" parents would pass on to their children.*[2]
>
> *… nativists feared that these demographic groups were reproducing too quickly for institutions to handle them all.*[2]
>
> *... near the turn of the century, scientists and doctors became less interested in helping these people and more interested in preventing them from reproducing.*[2]

A fear was raised that demographic groups assumed to be more genetically susceptible to "insanity" were reproducing too fast for government institutions to handle them.

Costs to the State became a concern and interest in building institutions to assist people with mental health conditions waned.

There was a consequent shift from helping people with mental health conditions to

preventing them from reproducing.

It was around this time, the census stopped asking about mental health.

The AMSAII, however, continued to do this and provided the Census Bureau with their statistics instead.

Who was the AMSAII?

> *At a meeting in 1844 in Philadelphia, thirteen superintendents and organizers of insane asylums and hospitals formed the Association of Medical Superintendents of American Institutions for the Insane (AMSAII).* [6]
>
> *The group was chartered to focus "primarily on the administration of hospitals and how that affected the care of patients", as opposed to conducting research or promoting the profession.*[6]

The AMSAII were **superintendents and organizers** of insane asylums **with a focus on the administration** of hospitals.

In 1893, the organization changed its name to The American Medico-Psychological Association and later, in 1921, **became the American Psychiatric Association.**

Statistical Manual for the Use of Institutions for the Insane

> *In 1917, the American Medico–Psychological Association, together with the National Commission on Mental Hygiene, developed a plan adopted by the Bureau of the Census for gathering uniform health statistics across mental hospitals.* [1]
>
> *Although this system devoted more attention to clinical usefulness than did previous systems, it was still primarily an administrative classification.*[1]
>
> *It was specifically designed for administrators of inpatient mental hospitals to use for collecting institutional data, rather than for guiding treatment of specific patients.*[1]

This Statistical Manual for the Use of Institutions for the Insane (often confused with the subsequent DSM) was never intended to be used for diagnosing people and the word “diagnosis” is not even mentioned in the title.

It was a manual, created for administrative purposes only, to share statistics between institutions and the government.

The Census Bureau was still gathering information on mental health, but now from institutions via this administrative manual.

STATISTICAL MANUAL

FOR THE USE OF

INSTITUTIONS FOR THE INSANE

PUBLISHED BY BUREAU OF STATISTICS
THE NATIONAL COMMITTEE FOR MENTAL HYGIENE
50 UNION SQUARE, NEW YORK CITY
1918

STATISTICAL MANUAL

FOR THE USE OF

INSTITUTIONS FOR THE INSANE

PREPARED BY THE

COMMITTEE ON STATISTICS

OF THE

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION

IN COLLABORATION WITH THE

BUREAU OF STATISTICS

OF THE

NATIONAL COMMITTEE FOR MENTAL HYGIENE

50 UNION SQUARE, NEW YORK CITY

NEW YORK
1918

It is recommended that the standardized tables be used in the annual reports of the institutions so far as possible and that a duplicate copy of the tables be sent to the Bureau of Uniform Statistics of the National Committee for Mental Hygiene as soon as possible after the end of the fiscal year of the institution.

ALBERT M. BARRETT, *Chairman*
E. STANLEY ABBOT
OWEN COPP
GEORGE H. KIRBY
JAMES V. MAY
FRANKWOOD E. WILLIAMS
Committee on Statistics, American Medico-Psychological Association

THOMAS W. SALMON
Medical Director, National Committee for Mental Hygiene

EDITH M. FURBUSH, *Statistician,*
HORATIO M. POLLOCK,
Consulting Statistician,
Bureau of Statistics, National Committee for Mental Hygiene

FOREWORD

The American Medico-Psychological Association at its meeting held in New York, in May 1917, adopted the report of its Committee on Statistics which provided for a system of uniform statistics in institutions for mental diseases, and appointed a standing Committee on Statistics to promote the introduction of the system throughout the country. This committee met in New York City on February 7, 1918, and in cooperation with the National Committee for Mental Hygiene outlined a plan of procedure.

The National Committee has established a Bureau of Uniform Statistics and has received a special gift to defray the initial expenses of the work of collecting statistics from institutions for the insane. As close relationships have always existed between the American Medico-Psychological Association and the National Committee, it was thought wise for the Committee on Statistics to become an advisory committee to the Bureau of Uniform Statistics of the National Committee and to have the work of introducing the new system and of collecting statistics from the institutions carried out by the Bureau.

In accordance with this arrangement the Bureau, with the assistance of the Committee on Statistics of the American Medico-Psychological Association, has prepared this manual to assist the institutions in compiling their annual statistics and has printed a series of forms to be used in preparing statistical reports. The manual and duplicate forms will be furnished free to all cooperating institutions, and it is earnestly hoped that they will be generally adopted, so that a national system of statistics of mental diseases may become an actuality.

In the Statistical Manual for Use of Institutions for the Insane:

> *Of its 22 principal groups only one, the psychoneuroses, reflected conditions found in noninstitutionalized patients.*[7]

In other words, the only group of conditions found in non-institutionalized patients (as well as those in institutions) are the “neuroses”. These “neuroses” were characterized by an anxiety that *seemed* disproportionate to the present situation.

> *The statistical manual (for Use of Institutions for the Insane) also reflected the view that the conditions it classified arose from somatic (relating to the body as opposed to the mind), constitutional (relating to someone’s general state of health), and heredity (genetic) factors.*[7]

Accordingly, treatments for such were somatic therapies i.e. physical intervention to the brain, body and nervous system functions.

Lobotomy anyone?

Treatments Change With Knowledge

Doctor Knows Best

> *Lobotomy, also called prefrontal leukotomy, surgical procedure in which the nerve pathways in a lobe or lobes of the brain are severed from those in other areas. The procedure was formerly used as a radical therapeutic measure to help grossly disturbed patients with schizophrenia, manic depression and mania (bipolar disorder), and other mental illnesses.*[8]
>
> *Evidence that surgical manipulation of the brain could calm patients first emerged in the late 1880s, when Swiss physician Gottlieb Burkhardt, who supervised an insane asylum... performed his operation on six patients, with the specific purpose* ***not of returning the patients to a state of sanity but of putting them into a state of calm*** *[my boldface].* [8]
>
> *One of Burkhardt's patients died several days following the operation, and another later committed suicide.* [8]

Regardless, the lobotomy took off as a medical procedure to treat mental health.

> *Lobotomies were performed on a wide scale during the 1940s; ... The practice gradually fell out of favour beginning in the mid-1950s,* ***when antipsychotics, antidepressants, and other medications that were much more effective in treating and alleviating the distress of mentally disturbed patients came into use****.[my boldface]* [8]

Chemical lobotomy anyone?

But how did the switch to a chemical intervention of brain function become popular and was the perspective of *Biological* psychiatry good medicine?

Please read on.

Post World War II

> *By this time, most mental-health professionals practiced in community sites, not in mental hospitals.* [7]
>
> *The Statistical Manual (for Use of Institutions for the Insane) offered little guidance for clinicians in outpatient settings. The psychotic conditions that dominated its classifications were no longer of high priority for the majority of therapists.* [7]
>
> *In addition, clinicians who used **psychodynamic perspectives that stressed psychological and social processes were coming to dominate outpatient psychiatry** [my boldface]. They had little use for the biological explanations that the Statistical manual (for Use of Institutions for the Insane) reflected.*[7]

Mental health professionals at this point (after WWII) were largely working with people who were not hospitalized. These professionals were less interested in blaming genetics or physical abnormalities of the body/brain and were more interested in a psychoanalytical approach to uncover the reasons *why* a person may have been struggling.

These mental health professionals were aware the war veterans they were trying to treat had a *logical* reason to be mentally distressed.

> *A much broader classification system was later developed by the U.S. Army (and modified by the Veterans Administration) to better incorporate the outpatient presentations of World War II servicemen and veterans (e.g., psychophysiological, personality, and acute disorders).*[7]

The U.S Army then developed its own mental health classification system based on what reactions and mental health challenges were being exhibited by its war veterans.

> *At the same time, the World Health Organization (WHO) published the sixth edition of the ICD (ICD- 6), which, for the first time, included a section for mental disorders.*[7]

ICD is the acronym for “International Classification of Diseases”

Today there are two established systems for classifying mental disorders:

1. The DSM (Diagnostic and Statistical Manual of Mental Disorders)
2. The ICD (International Classification of Diseases)

It is commonly thought that Europe generally uses the ICD to diagnose mental health disorders, while The U.S.A and a variety of other countries use the DSM as their diagnostic tool.

But, in fact, both are referred to for treatment and the two have been inextricably linked from their early development, which would explain why:

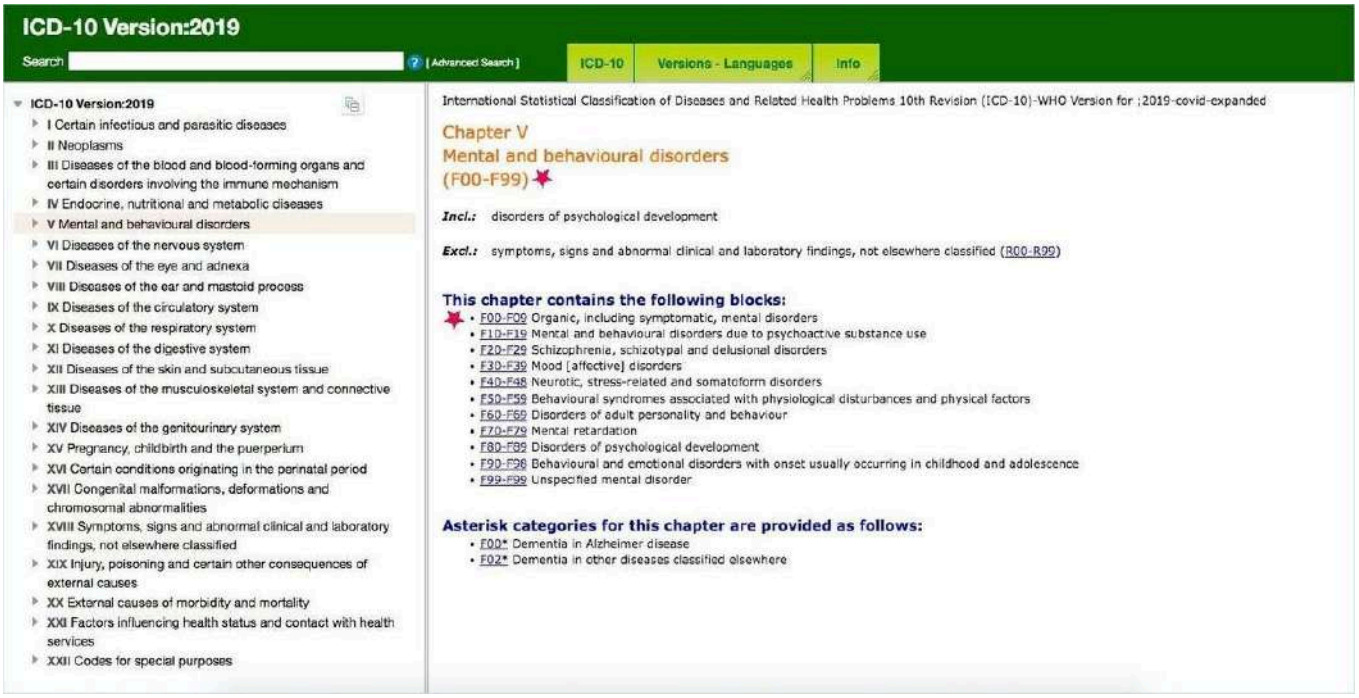
> ***ICD–6 was heavily influenced by the Veterans Administration classification*** *[my boldface] and included 10 categories for psychoses and psychoneuroses and seven categories for disorders of character, behavior, and intelligence.* [1]

So let's have a quick look at the development of the ICD, how this is connected to the DSM and what the implications of this may be.

International Classification of Diseases (ICD)

> *International Classification of **Diseases** [my boldface] (ICD), in medicine, **diagnostic tool** [my boldface] that is used to classify and monitor causes of injury and death and that maintains information for health analyses, such as the study of mortality (death) and morbidity (illness) trends.* [9]
>
> *The ICD is designed to promote **international** [my boldface] compatibility in health data collecting and reporting .* [9]

The ICD also lists diseases and assigns codes to them. These codes are used for medical administration purposes **and medical insurance claims**.



Screenshot taken from the ICD WHO website

The History of the ICD

> *Some scholars track the origin of ICD to 1763. The French physician and botanist Dr François Bossier de Sauvages de Lacroix developed a categorization of 10 distinct classes of diseases, which were further divided into 2400 unique diseases.*[10]

> **Nosology**
> (from Ancient Greek νόσος (**nosos**) 'disease',
>
> and -**λογία** (-logia) 'study of') is the branch of medical science that deals with the classification of diseases.
>
> Definition from Oxford Languages

François Boissier de Sauvages de Lacroix's classification was based on actual physical diseases and viruses.

But Lacroix then wrote a treatise...

> *Sauvages de Lacroix explained his nosology in the 1763 treatise Nosologia Methodica, a work that reportedly was an inspiration to Philippe Pinel (1745—1826) and his early research of mental illnesses.* [12]

And Philippe Pinel...

> *... made notable contributions to the classification of mental disorders and has been described by some as "the father of modern psychiatry".* [13]

It would make sense, then, that the "biological" approach to psychiatry became so easily accepted right from the beginning.

At the very least, this set up mental reactions to be easily confused with the classification and nomenclature of proper diseases. Or, at the very least, to be heavily influenced by this.

Isn't it interesting how personal interests and personal perspective influence "science"?

And then the interest grew…

> *Recognizing the importance of disease classification, the first International Statistical Congress held in Brussels in 1853 appointed Jacob Marc d'Espine and William Farr to develop a system of classifying causes of mortality that could be used across borders and languages.* [14] [original citation removed from WHO website]

This was the genesis of what became known as the "International List of Causes of Death." (ILCD) [14]

William Farr and Jacob Marc d'Espine created their own nosological classifications independently. Although they respected each other's work, they were at odds on the nomenclature chosen for their respective systems of classification.

> *After summarizing Farr's results, he (Marc d'Espine) gave details of the nosological classification used, and criticized its main division of diseases into "epidemic" and "sporadic", preferring instead that of "acute" and "chronic".* [17]
>
> *Farr replied promptly in a long footnote in the next Annual report of the Registrar-General. 4 He described Marc d'Espine's work approvingly, but rebutted his criticisms of the nosology.* [17]

Clearly, the importance of words was noted right from the beginning of these attempts at classification.

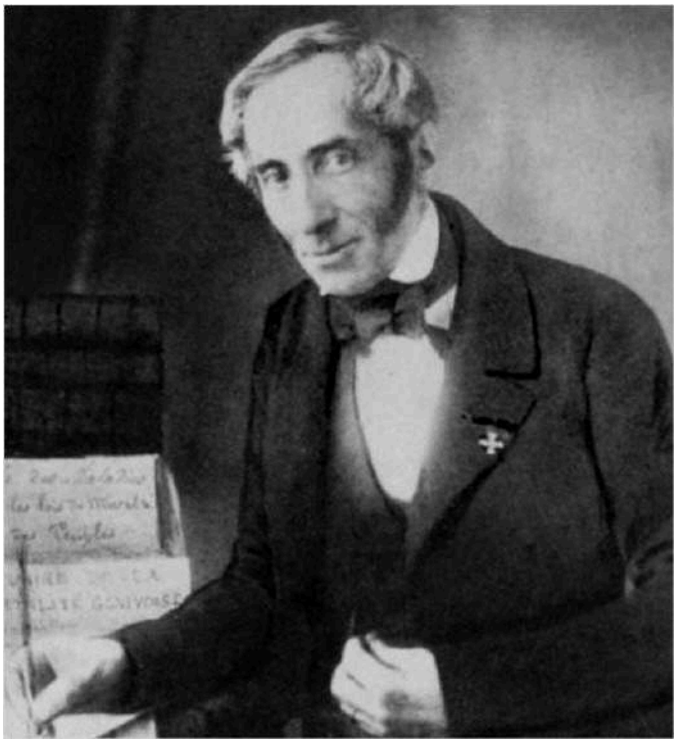
Due to Farr and d'Espine being unable to resolve the differences between their preferred terms/names, both forms were offered for consideration at the Paris Congress in 1855.

> *Farr and d'Espine submitted two separate lists of the causes of death.*[18]

William Farr

By Unknown author - Popular Science Monthly Volume 23, Public Domain

Original Image Source



Marc d'Espine

Porträt, um 1858. Nach einer alten Fotografie (Bibliothèque de Genève)

Found on HLS website

The Congress compromised and combined the lists but, after reading more on this, it seems Farr's list may have had a bit more influence on the final outcome.

But:

> *It must be admitted that at both Paris and Vienna there was considerable opposition to the desirability, or even possibility, of a standard list of causes of death.* [17]

> ***Some doctors present argued that statisticians had no right to dictate to medical men; that even a purely medical congress would find it impossible to agree on such a list; and that it would be an obstacle to progress and an infringement of their freedom to name diseases as they chose*** *[my boldface]. Again Congress reached no conclusion.* [17]
>
> *The International Statistical Congress held another five full sessions before its sudden collapse in 1878, but the subject of a standard international nosology was never raised again* [17]

The work of William Farr and Jacob Marc d'Espine would lay the foundation of what was to become the “International List of Causes of Death”

And so the classification began to develop.

> *The International Statistical Institute adopted the first international classification of diseases in 1893. The system was based on the Bertillon Classification of Causes of Death, developed by French statistician and demographer Jacques Bertillon.* [19]

Adolphe-Louis Jacques Bertillon

Bibliothèque nationale de France

Image Source Public domain, via Wikimedia Commons

> *Bertillon worked to establish uniform international statistical standards and saw his "Bertillon classification" of causes of deaths come into use in many nations.* [20]

Educated as a physician, but with a later focus on *statistics*, one of Bertillon's main areas of interest was the rise of alcoholism in France. He wrote a paper on the subject titled "L'Alcoolisme et les moyens de le combattre jugés par l'expérience". (1904; "Alcoholism and Ways of Combating It Judged from Experience")

This may explain how the "disease model" (the idea that alcoholism is a disease) became widely accepted as "medicine".

> *At around that time, the "(Bertillon) International **List of Causes of Death was presented in the United States** [my boldface] at the International Statistical Institute, and in 1898, various countries in North America, including the United States, adopted this system.* [14]

When the U.S adopted the system, **it did so under the proviso that the classification list was to be revised roughly every ten years**.

This was agreed upon and the next revisions took place in 1909, 1920, 1929 and 1938.

The Fifth Revision Conference

> *The Fifth International Conference for the Revision of the **International List of Causes of Death** [my boldface] (ILCD)... was convened by the Government of France and was held in Paris in October 1938.* [16]

> *... the Conference recognized the growing need for a corresponding list of diseases to meet the statistical requirements of widely differing organizations, **such as health insurance organizations** [my boldface], hospitals, military medical services, health administrations and similar bodies.* [16]

At this point, it was suggested that the classification lists of both diseases and deaths were combined into one manual.

The Conference also recommended that the United States Government continue its studies of the statistical treatment of joint causes of death "warmly" thanking the U.S.A, in its resolution, "for the work it has accomplished or promoted in this connection".

And ordered that:

> *Pending the compilation of international lists of diseases, the Conference recommends that the various **national lists in use** [my boldface] should, as far as possible, **be brought into line with the detailed International List of Causes of Death**. [my boldface] 16*

Sixth Revision of the International Lists

> *The International Health Conference **held in New York City** [my boldface] in June and July 1946 entrusted the Interim Commission of the World Health Organization with the responsibility of: 16*
>
> > *reviewing the existing machinery and of undertaking such preparatory work as may be necessary in connection with: 16*
> >
> > - *the next decennial revision of 'The International Lists of Causes of Death' (including the lists adopted under the International Agreement of 1934, relating to Statistics of Causes of Death); and*
> > - *the establishment of International Lists of Causes of Morbidity 16*
>
> *To meet this responsibility, **the Interim Commission appointed the Expert Committee** [my boldface] for the Preparation of the Sixth Decennial Revision of the International Lists of Diseases and Causes of Death. 16*

This Committee, taking full account of prevailing opinion concerning morbidity and mortality classification, reviewed and revised the above-mentioned proposed classification ***which had been prepared by the United States Committee*** *[my boldface] on Joint Causes of Death.* [16]

The Committee also compiled a list of ***diagnostic terms*** *[my boldface] to appear under each title of the classification.* [16]

The International Conference for the Sixth Revision... was convened in Paris from 26 to 30 April 1948 by the Government of France under the terms of the agreement signed at the close of the Fifth Revision Conference in 1938. [16]

Its secretariat was entrusted jointly to the competent French authorities ***and to the World Health Organization*** *[my boldface], which had carried out the preparatory work under the terms of the arrangement concluded by the governments represented at the International Health Conference in 1946.* *[Off.Rec. Wld. Hlth Org., 1948, 11, 23.] 16*

The Conference ***adopted the classification prepared by the Expert Committee*** *[my boldface] as the Sixth Revision of the International Lists.* [20] *[Off.Rec. Wld. Hlth Org., 1948, 2, 110] 16*

Here we see why the sixth revision of the ICD (ICD-6),

... which was adopted from the classification prepared by the "Expert Committee",

... who was put in place by the "Interim Committee" of the "WHO" (that didn't exist yet),

... but who "reviewed and revised the above-mentioned proposed classification prepared by the United States Committee",

... may be said to be "heavily influenced by the U.S. war veterans manual'.

And, perhaps, some other influences as well.

Because **it's at this point that a list of diagnostic terms were added** to each title of the classification.

But who is WHO?

The World Health Organisation (WHO) was founded on 7 April 1948.

By Font: Adrian Frutiger, Logotype: The World Health Organization - Website and publications of the World Health Organization:Source 1Source 2, Public Domain

> The founding year of WHO, 1948, was the same year they took charge of the decennial revision of the list (ILCD).

On 7 April 1948, only a fortnight prior to the The International Conference for the Sixth Revision of the International Lists of Diseases and Causes of Death, WHO suddenly appeared.

I'm uncertain as to how there could have been an "interim commission" for an organization that was not yet in place, or why The International Health Conference **held in New York City** would entrust them with the responsibilities mentioned above.

Or why this "Interim Commission" for WHO would appoint an "Expert Committee" to review and revise a proposed classification system prepared by the United States Committee.

Or why the The International Conference for the Sixth Revision of the International Lists of Diseases and Causes of Death "adopted the classification prepared by the Expert Committee as the Sixth Revision of the International Lists." [Off.Rec. Wld. Hlth Org., 1948, 2, 110] 16

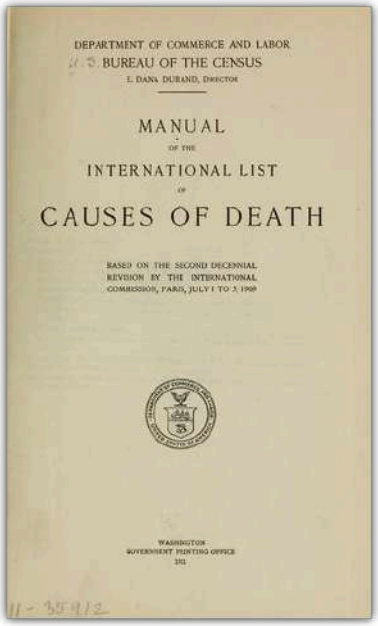
But it was at this point that **diagnostic codes** were added to the list/manual as well:

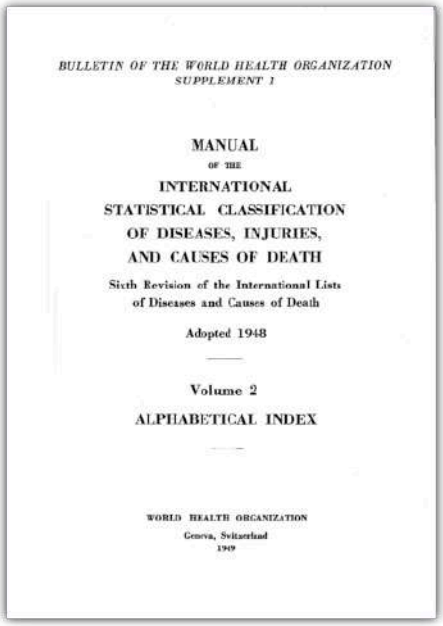
> *In 1948, the World Health Organization (WHO) took charge of the classification system, which was expanded the following year* ***to include coding for causes of morbidity*** *[my boldface] in addition to mortality. 14*

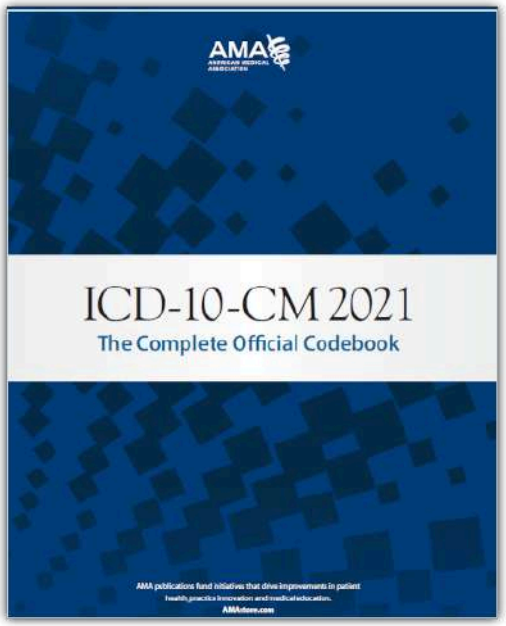
I do know that hospitals and medical professionals use these same codes, from the ICD, on their client invoices. And that these codes are required by medical insurance companies for medical cover and reimbursement.

In addition:

> *The system was rechristened the International* ***Classification of Disease system****. (ICD) [my boldface] 14*







Original Image Source: **1** | **2**

Surprisingly similar development to the DSM, isn't it?

Both manuals were initially developed for statistical reasons.

Both manuals transformed into medical diagnostic tools for mental "disorders", for which there are no physical markers of disease.

Both manuals kept almost identical acronyms, even though the title of the manuals were completely changed.

International List of Causes of Death (I ~~L~~ CD) to: Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death.

Or, these days, just International ~~Statistics~~ Classification of Diseases. (ICD)

Diagnostic Statistical Manual for Institutions for the Insane to: Diagnostic Statistical Manual of Mental Disorders (DSM commonly used to refer to both).

And although the current ICD is generally seen as independent to the DSM, there is a clear connection between the manuals and a European and American collaboration during their development.

And now we return to Post War America.

Post World War II (cont)

A recap:

The Statistical Manual (for Use of Institutions for the Insane) was not helpful to clinicians working in outpatient settings. Clinicians in these settings were also aware that the patients they were attending to had good reason for their challenges in a post war situation.

These clinicians were subsequently more interested in a *psychodynamic* (environmental causes for mental reactions) approach to treating their patients .

“Psychodynamics” looks at how a person's psychology (perception and thinking) impacts their behaviour, feelings and emotions, **in relation to external factors and early experience**.

A wider classification system, that incorporated the outpatient mental health challenges of its veterans, was also developed by the U.S Military and modified by its Veterans Administration around this time.

> *At the same time, the World Health Organization (WHO) published the sixth edition of ICD (ICD-6),*
>
> ***which, for the first time, included a section for mental disorders*** [my boldface]. [20]

So, heavily influenced by information gathered by the U.S military on the mental health challenges of its war veterans, The World Health Organization (WHO) added the U.S Army’s data to their international classification of diseases.

Despite there being no physical markers or physical symptoms of any kind of disease or illness.

WHO did, however, acknowledge there were mental health categories that were disorders of character, behaviour and intelligence (and not of the brain itself) in their classification of diseases manual.

And now we have a better understanding of *why* and *how* the ICD-6 was "heavily" influenced by the American War Veterans system of Classification.

Let's continue looking at how the American Diagnostic Statistical Manual for the Use of Institutions for the Insane, became the DSM of today.

A war Veteran would, in all likelihood, return from an ongoing high conflict situation with trauma in the form of Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (C-PTSD, which was only first acknowledged in 1992).

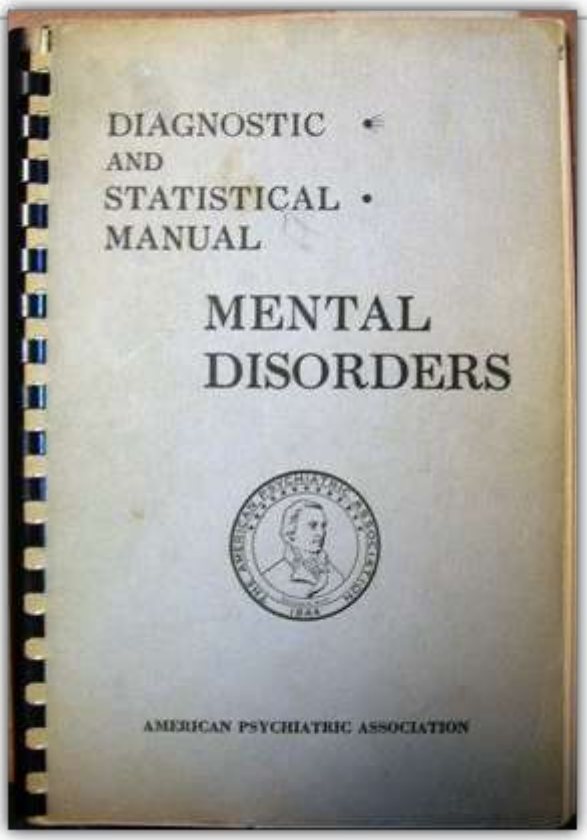
At this point there was little understanding of what PTSD and C-PTSD were or what perceptions, feelings and behaviours are displayed by a person with PTSD and C-PTSD.

So the U.S army creates a mental health classification system based on their war veterans (who would all be suffering from PTSD/C-PTSD) and the ICD uses this to create their world wide categories of mental illnesses/disorders.

And following this…

The APA (American Psychiatric Association) Committee on Nomenclature and Statistics developed a variant of the ICD–6 that was published in 1952 as the first edition of DSM (DSM-I).

20



Original Image Source

The administrative Statistical Manual for Use of Institutions for the Insane is then replaced with the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I).

It was at this point the word “Diagnostic” was added and the words “of Mental Disorders” replaced the words “for the Use of Institutions for the Insane” in the title of the manual.

It was at this point the Statistical Manual (for Use of Institutions for the Insane) transformed into the primary reference book that the majority of mental health professionals use to diagnose mental health disorders in both clinical and community settings in the U.S.A.

And a great many other countries as well.

It was at this point it became “the bible of psychiatry and psychology” as we know it today.

Developed off the back of a hospital administrative manual that was never meant to be a guide to treating people. Which was aimed at classifying inpatients who were severely impaired enough to be institutionalized.

With a biological perspective on the causes of mental health conditions that encouraged pretty barbaric and dangerously radical physical interventions as treatments. Off the back of a government census that relied on census officials, heads of families and slave owners to decide who was or was not sane.

As a variant of WHO’s manual of International **Disease** Classifications, which was heavily influenced by mental health classifications by the U.S military service of its war veterans.

Who were probably struggling with as yet undiagnosed, misdiagnosed and misunderstood PTSD and C-PTSD.

What could possibly go wrong?

The Lithium Experiment

Interestingly enough, the use of Lithium to treat mental health conditions was first tested by John Cade in Australia in **1948**.

Cade had tested the use of Lithium on himself and had experienced no adverse effects. He then decided to try it on Bill Brand, a patient who had been psychotic and institutionalized for around thirty years.

Within a few weeks Bill Brand's condition had substantially improved.

Within about two months of beginning treatment, he was able to return home.

Brand then stopped taking the medication and his mental health declined, to the point that he was returned to the institution, again. Without knowing the correct dosage due to it being an experimental treatment, Cade upped the dose and Bill Brand died.

Cade began his experimental use of Lithium on Bill Brand in March 1948.

One month prior to the Sixth Revision of the International Lists, the sudden appearance of the World Health Organisation and the addition of a new section of mental disorders, diagnostic terms and a coding system to the ICD.

A few years later, in the same year that the first U.S. Diagnostic Manual (DSM-I) was published (**1952**), what was soon to become the psychiatric drug of choice at the time, Chlorpromazine, was given to a patient.

In the same decade, Julius Axelrod carried out research into the brain’s neurotransmitters that won him the Nobel Prize for Physiology and Medicine.

This was impetus for further development of psychiatric medicines as neurochemistry became better understood.

And so began the rise of psychiatric medication.

Lithium is still listed on the World Health Organization's List of Essential Medicines in the 22nd List - 2021.

How Things Change

The DSM-I

We now know the DSM-I was developed due to the change of circumstances in treating people with mental health conditions after the war:

Mental health practitioners suddenly found the Diagnostic Statistical Manual for the Use of Institutions for the Insane unhelpful for the war veterans they were trying to assist, because only a small minority of the war veterans (in outpatient settings) matched the cases in mental hospitals.

Mental health practitioners, now working with outpatients, were also aware that the war veterans they were trying to treat had been exposed to extremely stressful situations.

Mental health practitioners trying to assist these war veterans had a more rational, **psychosocial** (psychodynamic) perspective on mental health challenges.

> ***psychosocial***
>
> > *adj. describing the intersection and interaction of social, cultural, and environmental influences on the mind and behavior.* [22]

> *The relationship between psychological factors and the physical body can be influenced by social factors, the effects of which are mediated through psychological understanding.* [23]

> *Examples of psychosocial factors include social support, loneliness, marriage status, social disruption, bereavement, work environment, social status, and social integration.* [23]

> *… it (the DSM-I) combined the psychoanalytic approach of Sigmund Freud, which emphasized the unconscious forces that he presumed to underlie mental illness, with the life-course approach of American psychiatrist Adolf Meyer, which focused on how mental illnesses were* ***reactions to challenges that individuals faced in adjusting to their***

> ***environments*** *[my boldface]*.
>
> ***It made no sharp distinctions between mental illness and mental health*** *[my boldface]*. [7]
>
> *It was driven by psychodynamic assumptions that were* ***more concerned with the underlying problems patients had than with the overt symptoms they displayed*** *[my boldface]*. [7]

In other words, clinicians were focused on treating the *reasons* that people were suffering instead of medicating their *symptoms***.**

In the DSM-I, mental health conditions were still separated into two major groups.

1. Physical/biological abnormalities
2. Psychological reactions.

But there was a new trend towards understanding how past experience, external environment and current perception impact brain and physical function, instead of the prior belief that biology was entirely responsible for mental health conditions.

The DSM-I listed **category names**, with a brief paragraph **describing the behaviours** associated with them.

The category names used the word “**reactions**” to explain the behaviors associated with them, instead of the word “disorders” we see added to every category name today.

This is a far more accurate observation of mental health challenges and might be far more beneficial, for successful treatment, for those who are suffering with them.

The DSM-I:

> *called all the functional disorders "**reactions**" [my boldface] (e.g., "schizophrenic reaction" or "depressive reaction") because, **unlike organic brain disturbances, they arose in response to patients' life histories and social environments** [my boldface]. [7]*

In other words, many mental health practitioners believed the underlying cause of all mental distress (that was not due to physical trauma/abnormality of physical brain structure) was caused by neurosis.

---

neurosis

noun [C or U]

a mental illness resulting in high levels of anxiety, unreasonable fears and behaviour and, often, a need to repeat actions for no reason. [24]

According to Sigmund Freud (1856-1939), a famous Austrian neurologist who founded the discipline of psychoanalysis, neurosis is a coping strategy caused by unsuccessfully repressed emotions from past experiences. [25]

He gave the example of an overwhelming fear of dogs that may have resulted from a dog-attack earlier in life. [25]

A conflict between two psychic events: Carl Gustav Jung (1875-1961) was a Swiss psychiatrist who founded analytical psychology. He believed that a neurosis was a clash of conscious and unconscious events in the mind. [25]

*These stances on neurosis confirm that it is seen as an ailment, and is normally discussed **with an aim to finding the cause of and treating the condition** [my boldface]. While a personality test can confirm that a person has neuroticism, **it is not a disease or condition and cannot be "treated."** [my boldface] [25]*

With a focus on psycho*analytic* theory, mental health practitioners viewed the categories of behaviours (now called mental disorders) as neuroses that were created by an underlying conscious or unconscious anxiety.

The subsequent behaviours associated with these neuroses were adopted as an attempt by the individual to manage this anxiety.

The description in the DSM-I for the main Psychoneurotic **reactions** category read:

> *"The chief characteristic of these disorders is "anxiety" which may be directly felt and expressed or which may be unconsciously and automatically controlled by the utilization of various psychological defense mechanisms (depression, conversion, displacement, etc.)* [26]
>
> *Anxiety, by definition, expressed defense mechanisms that were largely unconscious and* ***that emerged from some inner threat*** *[[my boldface]*. [7]
>
> *It is produced by a threat from within the personality (e.g.,* ***by supercharged repressed emotions*** *[my boldface], including such aggressive impulses as hostility and resentment), with or without stimulation from such external situations as loss of love, loss of prestige, or threat of injury."* [26]
>
> > *… the ways patients* ***expressed anxiety, through such mechanisms as "depression, conversion, or displacement*** *[my boldface]," were* ***secondary*** *[my boldface] to the fundamental process of anxiety that was behind each overt manifestation.* [7]

The "disorders" of today (e.g BiPolar Disorder) **were only considered to be the symptoms/reactions** to this main underlying cause of conscious or unconscious anxiety by many clinicians in the 1950's**.**

Depression was considered to be a **reaction** to an underlying anxiety, such as a repressed threat of assault which may have been experienced in the past, that was triggered as a coping mechanism when a person was reminded of the past event.

The Bipolar **reactions** (mania, depression) **were not disorders in and of themselves**.
Which is what we have been led to believe they are today ("BiPolar Disorder").

Or worse... that the person themselves is disordered. (He/She is BiPolar)

Manic and depressive symptoms were believed to be reactions, set off by environmental circumstances that had triggered conscious or unconscious memories of unresolved trauma.

So in accordance with this more rational, logical and psychodynamic approach to mental health challenges the DSM-I refers to depression as **"**Depressive **Reaction"** and has the following description:

> *"The anxiety in this reaction is allayed, and hence partially relieved, by depression and self-depreciation. The reaction is precipitated by a current situation, frequently by some loss sustained by the patient, and is often associated with a feeling of guilt for past failures of deeds."* [26] *(American Psychiatric Association, 1952, pp. 33–34)*

In other words, something in a current situation brings this anxiety into play and the **reaction** (depressive reaction for example) relieves the anxiety in some way.

The description of depressive reaction also mentions that the reaction "is often associated with a feeling of guilt for past failures of deeds".

Guilt and shame are primary feelings associated with unresolved trauma.

And "anxiety" (or the constant sensation of being on "high alert") is one of the most common effects of unresolved **Post Traumatic Stress ~~Disorder~~** ***Reaction***.

From here on I’m reverting to the psychodynamic perspective. As used by the DSM-I, I’m replacing the word “disorder” with “reaction”.

I’m also replacing the word “symptoms”, and any other medicalised references, with the word **reactions**.

Because these are not “medical illnesses”.

And these are not incurable "disorders" in my personal experience.

My reasoning will make sense if you read on.

What the DSM-I describes in the above paragraph referring to depressive reaction, is identical to what we would now understand to be a type of C-PTSR “flashback”. Simply put… a “trigger” in the present environment or situation causes a “flashback” (often unconsciously) reminding the person of a past traumatic event or circumstances…

and the perception and feelings associated with the past event become overlaid onto the present moment.

This is how trauma “works”.

But we will look more at how trauma works (and why some people aren’t even aware they have trauma) in the next chapter, where it will also become clearer as to what the many mental health "disorders" of today may possibly be.

But before we do, here is a story that proves Freud and Jung’s perspective worked!

An Interesting Story

"We cannot change anything until we accept it.
Condemnation does not liberate, it oppresses."

Carl Gustav Jung

THE YEAR IS 1904

Sabina Nikolayevna Spielrein was a Russian physician and one of the first female psychoanalysts. She was in succession the patient, then student, then colleague of Carl Gustav Jung… [27]

Following the sudden death of her only sister Emilia from typhoid, Spielrein's mental health started to deteriorate, and at the age of 18 she suffered a breakdown with severe hysteria including tics, grimaces, and uncontrollable laughing and crying. [27]

After an unsuccessful stay in a Swiss sanatorium, where she developed another infatuation with one of the doctors, she was admitted to the Burghölzli mental hospital near Zurich in August 1904. Its director was Eugen Bleuler, who ran it as a therapeutic community with social activities for the patients including gardening, drama and scientific lectures. [27]

One of Bleuler's assistants was Carl Jung, afterwards appointed as deputy director. In the days following her admission, Spielrein disclosed to Jung that her father had often beaten her, and that she was troubled by (sexual) masochistic fantasies of being beaten. [27]

Original Image Source: Carl Jung: By Unbekannt - This image is from the collection of the ETH-Bibliothek and has been published on Wikimedia Commons as part of a cooperation with Wikimedia CH. Corrections and additional information are welcome., Public Domain, https://commons.wikimedia.org | By Unknown author - Family photo, Public Domain (https://commons.wikimedia.org/w/index.php?curid=45881873/w/index.php?curid=94177705)

Bleuler ensured that she was separated from her family, later requiring her father and brothers to have no contact with her. [27]

She made a rapid recovery, and by October was able to apply for medical school and to start assisting Jung with word association tests in his laboratory. Between October and January, Jung carried out word association tests on her, and also used some rudimentary psychoanalytic techniques. [27]

Later, he referred to her twice in letters to Freud as his first analytic case, although in his publications he referred to two later patients in these terms." [27]

Sabina Nikolayevna Spielrein made a full recovery and went on to become a leading Psychoanalyst in her own right.

Psychoanalysis worked.

The psychodynamic, psychosocial approach worked.

Mental health professionals had already gained enough insight to "cure" mental "illness".

But somehow, in 2022, the latest version of the DSM claims this reaction to be a disorder and modern treatment commonly includes psychiatric medication. For lifetimes.

How did we progress to this point and is this progress?

The DSM-II

The next edition of the manual, the DSM-II, was issued in 1968. It made some changes to the DSM-I, mostly to make the nomenclature more compatible with the World Health Organization's International classification of diseases (ICD). [7]

The DSM-II is where the vocabulary used to describe these reactions begins to change.

> *Although the DSM-II no longer used the term "reaction" (e.g. "Schizophrenic Reaction" became "Schizophrenia," "Phobic Reaction" became "Phobic Neurosis," etc.), the second edition maintained the general psychodynamic orientation of the first DSM.* [7]
>
> *It made few changes in the definitions of the various diagnoses and continued to describe each condition in perfunctory and theory-infused ways. For example, its definition of depression (now called "depressive neurosis") stated: "This disorder is manifested by an excessive reaction of depression due to an internal conflict or to an identifiable event such as the loss of a love object or cherished possession".* [7]
>
> *Both manuals focused on psychodynamic explanations that directed attention toward the total personality and life experiences of each individual patient [my boldface].* [7]

So the word "reaction" is replaced by the word "neurosis" and the word "disorder" first appears. Although "disorder" is first used only in the *description* of the **behaviours** associated with the

“neurosis” in the above paragraph taken from the DSM-II.

A strong move away from a psychoanalytic perspective, however, towards a biological perspective of disease, genetics and medical illnesses had begun. And this *medicalised* view became the mainstream perspective 1980, when the DSM-III was released.

In the 1980, the word “disorders” replaced the word “neurosis” and was added to *every* category of reactions in “the bible of psychiatry and psychology”.

And people, who may have had the rational causes of their mental reactions addressed and healed, began to be considered medically ill and in need of chronic psychiatric medications.

Sometimes for lifetimes.

But how and **why** did this happen?

While the terminology, in the DSM-II, for these reactions was becoming more medicalised, the focus on treatment was still generally holistic and psychodynamic.

Mental health practitioners focused on understanding the individual and finding the reason for behaviours. The focus was on understanding why there was neurosis (psychological conflict), in order to help people integrate their personal experience and accept it, and themselves, fully.

This was the process, and goal, of "individuation" that Carl Jung referred to.

It was not necessary, with this approach, to assign a *diagnosis* to a person suffering with mental health challenges.

Even more importantly, specific diagnoses had little role to play in the explanations and treatments of dynamic psychiatry or in mental health practice. [7]

> *Psychodynamic therapies were largely nonspecific, so particular diagnoses were unnecessary for guiding treatment plans. Most outpatients at the time paid for their own therapy so that no private or public third parties required diagnoses to reimburse clinicians.* [7]

> *In addition, during the 1950s and 1960s drug companies generally touted many of their products as allaying broad conditions such as stress, nerves, or anxiety,* ***not as responses to particular types of mental disorders*** *[my boldface].* [7]

There was no need to make a diagnosis in order to claim funds back from health insurance to cover treatment. Yet.

> *The absence of specific definitions of the conditions found in the DSM-I and DSM-II were not liabilities for mental health practitioners or the pharmaceutical industry during the 1950s and 1960s.* [7]

Enough said.

And now human ego and greed become clearly involved.

A Wrong Turn

It happens in the institutions of education where, to this day, mental health professionals are "taught" what they now "know".

While departments of psychiatry in communities and institutions were still dominated by psychoanalysts who were focused on Freudian theories, psychiatrists were not being taken seriously **because psychoanalysis was not considered science or medicine**.

> *"I remember one meeting, when I told a psychiatry professor about a study I had read showing that no two psychiatrists could agree better than chance on diagnosis," says retired Washington University psychiatrist George E. Murphy, MD. "He said, 'But then our diagnoses don't mean anything,' and I replied, 'That's exactly true.' And he never spoke to me again, because that was too bitter a pill to swallow.* [28]

In the 50's and 60's, however, academic papers on psychiatry at universities were not being taken seriously and **academics were unable to get funding and grants to further their studies**.

As a result of this, there was a strong move towards developing a more scientific model of psychiatry.

In an interesting article I found, Washington University is specifically mentioned as a forerunner in this shift towards a more scientific approach to mental health conditions.

> *In their profound disagreement with the psychoanalytic model — and their determination to forge a new, evidence-based brand of psychiatry — Washington University psychiatrists stood virtually alone. At scientific meetings, they were often shunned, their papers ignored; they faced rejection upon rejection in applying for research grants. But they persevered.* [28]
>
> *"There was a spirit in that department of open thinking about psychiatric illness, a kind of freefloating intellectual energy," says Charles F. Zorumski, MD, the Samuel B. Guze Professor and head of the Department of Psychiatry at Washington University School of Medicine in St. Louis. "The faculty were very bright and very articulate, and the place became a magnet for these creative people to come together."* [28]

Creative people.

Because psychology is not science.

Again. **It is philosophy and personal opinion at best**.

It's important to note here that a psychologist is not a medical doctor.

> *So, what is the difference between a psychologist vs a psychiatrist? A psychologist studies how our brains and our bodies communicate with each other. A psychiatrist studies how medication and psychotherapy can be used to treat various mental and behavioural disorders. Psychiatrists prescribe medication. Psychologists don't.* [29]

But in the 50's and 60's even psychiatrists weren't considered to be real doctors because the psychoanalytic approach to treating mental health conditions was not considered medicine or science.

This resulted in those working in the health arena, such as psychologists and social workers, saying they were just as qualified as psychiatrists to treat people with the popular psychodynamic approach..

> *Psychiatrists were also challenged by other mental health professionals such as clinical psychologists and social workers who argued that they possessed as much training and skill to study and treat psychosocially defined conditions.* [7]

> *There was, in other words, nothing explicitly psychiatric about the assumptions of the first two DSMs: non-medical and medical professionals alike could diagnose and manage most of the entities that they defined.* [7]

There was not much respect for the psychiatric field at all.

This drove academics, the students and researchers of psychiatry, towards a more medical perspective that might be considered more scientific.

These:

> **... university psychiatrists moved their field toward a new "medical model" of psychiatry* ***that culminated in the publication of the DSM-III in 1980*** *[my boldface].* [28]

It was in the revision of the DSM-II (to the DSM-III) that the word "disorder" replaced the word

---

"neurosis" in full and all reference to the psychodynamic approach to mental health conditions was eradicated in one fell swoop:

And here is how it happened.

The DSM-III Task Force

> *In 1942, Washington University's [my boldface] combined Department of Psychiatry and Neurology attracted a new head, Edwin F. Gildea, MD, a Yale psychiatrist* ***and dedicated researcher*** [my boldface]. [28]

> *A Harvard colleague, Mandel Cohen, MD, was delighted at Gildea's appointment. A staunch foe of psychoanalysis in a city dominated by analysts, Cohen was eager to spread his scientific approach, and he urged a talented protégé, Eli Robins, MD, to accept an appointment in Gildea's department*. [28]

> *Robins arrived at the university in 1949 with his wife, Lee Nelken Robins, PhD, later a key founder of psychiatric epidemiology. In 1954 came George Winokur, MD, a strident enemy of psychoanalysis, followed the next year by Samuel B. Guze, MD, a skilled internist who shifted to psychiatry.* [28]

> *These three worked closely and collegially, joined by others: Murphy, Richard W. Hudgens, MD, Robert A. Woodruff Jr., MD, Paula J. Clayton, MD, Ferris N. Pitts, MD, Donald W. Goodwin, MD, and Rodrigo A. Muñoz, MD.* [28]

The **academic** psychiatrists at Washington University start a band that includes as many opposers of psychoanalysis as possible.

Robert L. Spitzer was then asked to chair the American Psychiatric Association's task force to develop the DSM-III because he was directly involved in the development of the DSM-II as well.

Who was Robert Spitzer, you may wonder?

> *Spitzer was a major architect of the modern classification of mental disorders.* [30]

> *He developed psychiatric methods that focused on asking specific interview questions to get at a diagnosis as opposed to the open-ended questioning of psychoanalysis, which was the predominant technique of mental health. He co-developed the Mood Disorder Questionnaire (MDQ), a screening technique used for diagnosing bipolar disorder. He also co-developed the Patient Health Questionnaire (PRIME-MD) which can be self-administered to find out if one has a mental illness.* [30]

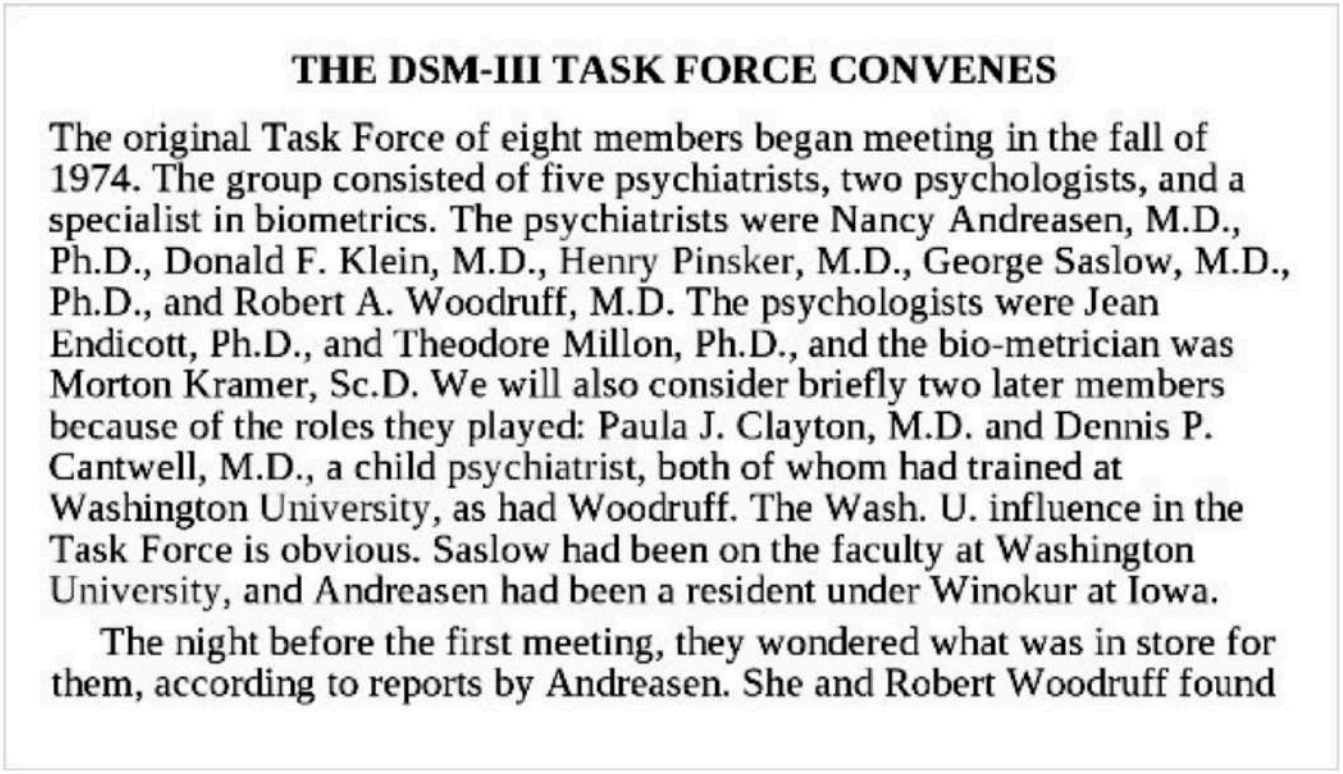
Some years later..

> *Spitzer was briefly featured in the 2007 BBC TV series The Trap, in which he stated that the DSM, by operationalising the definitions of mental disorders while paying little attention to the context in which the symptoms occur [my boldface], may have medicalised the normal human experiences of a significant number of people.* *[my boldface]* 30

But by 2007 the damage had, long since, already been done.

Back in the 70's, however, Spitzer was still interested in formalizing diagnoses into a more medical, scientific model.

It makes sense that Spitzer selected five members (out of the nine on the task force for the DSM-III) who had trained, or had been educated, at **Washington University**.



THE DSM-III TASK FORCE CONVENES

The original Task Force of eight members began meeting in the fall of 1974. The group consisted of five psychiatrists, two psychologists, and a specialist in biometrics. The psychiatrists were Nancy Andreasen, M.D., Ph.D., Donald F. Klein, M.D., Henry Pinsker, M.D., George Saslow, M.D., Ph.D., and Robert A. Woodruff, M.D. The psychologists were Jean Endicott, Ph.D., and Theodore Millon, Ph.D., and the bio-metrician was Morton Kramer, Sc.D. We will also consider briefly two later members because of the roles they played: Paula J. Clayton, M.D. and Dennis P. Cantwell, M.D., a child psychiatrist, both of whom had trained at Washington University, as had Woodruff. The Wash. U. influence in the Task Force is obvious. Saslow had been on the faculty at Washington University, and Andreasen had been a resident under Winokur at Iowa.

The night before the first meeting, they wondered what was in store for them, according to reports by Andreasen. She and Robert Woodruff found

Screenshot taken from The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry

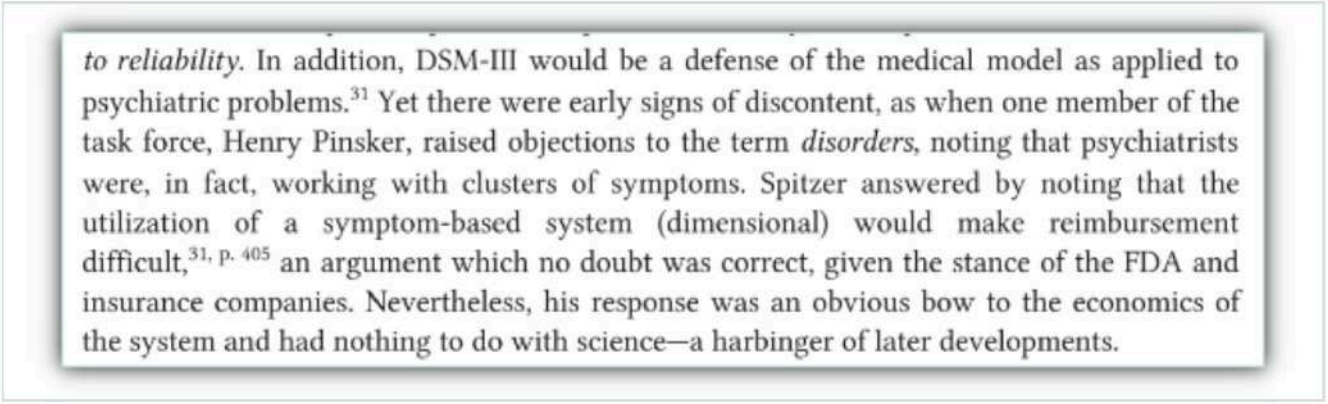
All of whom had a **biological** (medical) perspective on the causes of mental health conditions and some of whom Spitzer had personally collaborated with prior to his position as head of the task force.

> *Biological psychiatrists... emphasized the grounding of mental illness in brain structures and functions.* [7]
>
> ***They also employed psychoactive drugs as opposed to talk therapies*** *[my boldface] as the first-line response to psychiatric conditions.* [7]

During meetings for what was to become a radical shift towards a medical perspective on mental health, there was only one person on the committee who has been said to have had concerns about the new nomenclature.

Dr Pinsker, coming from a psychoanalytic approach, raised an objection to the term “disorders” being added to the **categories of behaviours** in the DSM.

To which Spitzer replied that reimbursement from medical insurance would be difficult if the classifications were based on sets of symptoms and were not specific.



to reliability. In addition, DSM-III would be a defense of the medical model as applied to psychiatric problems.[31] Yet there were early signs of discontent, as when one member of the task force, Henry Pinsker, raised objections to the term *disorders*, noting that psychiatrists were, in fact, working with clusters of symptoms. Spitzer answered by noting that the utilization of a symptom-based system (dimensional) would make reimbursement difficult,[31, p. 405] an argument which no doubt was correct, given the stance of the FDA and insurance companies. Nevertheless, his response was an obvious bow to the economics of the system and had nothing to do with science—a harbinger of later developments.

Screenshot from : "On the Risks and Benefits of Antipsychotics, Antidepressants, Psychiatric Diagnoses, and Neuromania", By Charles E. Dean

This concern was valid because:

> *In the 1970s psychiatrists confronted a new economic context. Government and private insurance programs were beginning to pay for most outpatient treatment. The vague and amorphous conditions in the DSM-I and DSM-II did not fit an insurance logic that required that clinicians treat a distinct disease.* [7]

> *This ... required a system that could more precisely measure the conditions that clinicians were treating.* ***The economic well-being of psychiatrists and other mental health professionals began to depend on their ability to treat specific, reimbursable conditions*** *[my boldface]*. [7]

In addition…

> *… the Food and Drug Administration began to enforce its rule that psychoactive medications could only be promoted as treatments for specific, well-recognised psychiatric disorders but not for psychosocial problems or general distress.* [7]

I found an interesting paper by Spitzer where he shares more about his personal history:

> *"I wrote the paper, "An Examination of Wilhelm Reich's Demonstration of Orgone Energy" (my first scientific paper), describing these experiments and the negative results.* [31]
>
> *I submitted the paper to the American Journal of Psychiatry, which rejected it. Soon thereafter, while still at Cornell,* ***I was visited by someone from the Food and Drug Administration*** *[my boldface], who explained that the government was attempting to stop Reich from distributing orgone accumulators. He asked me if I would be willing to serve as an expert government witness against Reich. Apparently, the FDA had asked the American Psychiatric Association (APA) who they could recommend as an expert on Reich's orgone theories. The APA suggested that the FDA contact a premedical student at Cornell (me) who had recently conducted some experiments on Reich's theories of orgone energy."* [31]

I have no wish to paint any of the task force members as malevolent human beings. Many of them, in later interviews, go on to say that they had little idea things would end up the way they did.

As in the alarming amount of new "diagnoses" that have been created, the loss of traditional psychoanalysis in treatment of mental health conditions and the inordinate amount of psychiatric medications now being prescribed as standard practice.

They were human beings with their own personal perspectives and opinions. Driven by their own personal motives. The same as most human beings are, really.

Hence, when decisions were made to change the nomenclature in the DSM-III it was only Henry Pinsker who raised an objection to the word "disorder" replacing the word "neurosis" in full.

Other than this, there has been mention of how delighted the task force was to, so easily, have reached decisions on their revision of the DSM.

Perhaps that's because the DSM-III task force was a small group of individuals with an already mostly agreed upon opinion…

which is what psychology is.

Opinion.

The revision of the DSM (DSM-III) was the opinion of nine odd people who were all Caucasian and mostly male (7 men; 2 women) Americans.

Many of whom had a personal motivation to be taken more seriously professionally and to be able to access funds for further academic research.

Which would also facilitate mental health professionals being able to add an ICD code to invoices.

Which would enable clients to claim funds back from insurance.

Funds from medical insurance companies who would not pay out insurance for "patients" who did not have some kind of medical illness or “disorder”.

Which would facilitate an increase in the number of people who would be able to afford private treatment.

And prescriptions of psychiatric medication.

Of course.

For which the FDA had begun to enforce stricter measures.

There was more than enough motivation to medicalise these conditions as quickly as possible.

We all know how lucrative the multi-billion dollar pharmaceutical industry is.

As is private treatment for mental health and addiction.

The Rise of Psychiatric Medication

As drug companies began their marketing campaigns in earnest, psychiatric medication became popular as a first line of treatment for mental health reactions.

The Official Newspaper of the American Psychiatric Association (the Psychiatric News) Vol IV No.1 (January 1969) has nineteen half to full pages of advertisements for psychiatric medications.

With multiple full page journal articles that promote the use of them as well.

Court Overturns Illegitimacy Decision

THE MARYLAND COURT OF APPEALS, the state's highest court, has reversed a lower court's ruling that the presence of illegitimate children in a household is *prima facie* evidence of a morally unstable environment and that such children are therefore neglected and can be taken from the mother [*Psychiatric News*, November].

The original case involved three mothers who applied for welfare benefits for their total of 11 children, all of whom were illegitimate. The Maryland state attorney subsequently filed charges of child neglect based solely on the grounds that illegitimacy among the children constitutes neglect of the children. A Maryland judge ruled in favor of the state's position, holding that a second pregnancy resulting from illicit sexual relations "represents a lack of judgment and demonstrates an unstable moral attitude on the part of the mother. . . ." He declared that children in such a situation should be taken from the mother's custody.

In reversing the original ruling, the court of appeals held that the evidence used by the state attorney in the original prosecution—the welfare applications—"was not intended and cannot lawfully be used" to prosecute the mothers. It further declared that "the ultimate consideration in finding neglect which will serve as a basis for removing a child from its mother's custody is the best interest of the child. The best interest of the child may or may not be served by removing it from the custody of the mother who has had another illegitimate child, but the sole test, automatically applied, cannot in fact or law be pregnancy with an illegitimate child. . . ."

The court of appeals also commented that the apparent purpose of the original prosecutions was to discourage promiscuity among welfare recipients, "a laudable goal," but one which cannot be sought in violation of law. It said that it is not permissible to "use children as pawns in a plan to punish the mothers."

Freud Work Published

A WORK OF Sigmund Freud once hailed as an achievement that "alone would suffice to assure Freud's name a permanent place in clinical neurology" has been published in English for the first time.

Infant Cerebral Paralysis, written about a decade after Freud received his medical degree, was translated into English by Dr. Lester A. Russin, director of the orthopedics section of the surgery department at Mount Sinai Hospital in Miami Beach. At the time of its original release in German, the work was hailed by Dr. Bernard Sachs as "masterly and exhaustive."

The University of Miami Press is the publisher.

Parent Clinics' Liability For Affiliates Questioned

THE LEGAL RESPONSIBILITY of a parent facility for the practice or malpractice of its affiliates within a multi-facility community mental health center is a nebulous area which requires considerable study and carefully executed contracts between facilities, according to a National Institute of Mental Health official.

Mrs. Rollee Lowenstein, chief of the NIMH Legislative Services Branch, wrote recently that the subject of responsibility of one facility for the actions of another is a part of the "virgin subject matter" of community mental health about which administrators ought to concern themselves before a problem arises.

Writing in the November issue of *Alabama Mental Health*, Mrs. Lowenstein pointed out that 70 percent of the community mental health centers funded consist of amalgamations of several different agencies spread over a community, each a separate and independent legal entity. Since the applicant for federal funds must give "specific and detailed information and adequate assurances" that any agencies affiliated with it will comply with the agreements of the application and federal regulations, the parent body accepts a large responsibility.

"One of the most vital of these," Mrs. Lowenstein said, "is the requirement for complete continuity of care. . . . A patient being treated in one service of the center must be transferred to and receive treatment in every other service when clinically indicated. . . . How can the applicant be sure that each separate organization [will provide services which] will comply with all federal requirements and, beyond this, will share common goals and treatment philosophy?"

According to Mrs. Lowenstein, a related issue is the question of responsibility for negligence or malpractice. As a general rule, she said, "the question of liability of the parent component for the negligent acts of its affiliate is dependent on the question of control. Because federal regulations require the parent agency to exercise general medical supervision over all component program activities, the parent may well be held responsible for the activities of its affiliate under the legal doctrine of *respondeat superior* ('let the master answer')."

For the protection of both parties, Mrs. Lowenstein suggests that parent bodies and affiliates enter into clearly detailed affiliation agreements, preferably in contract form. "The affiliate," she said, "need not surrender all of its autonomy or independence as an operating institution. As a minimum, however, it must bind itself to accept the conditions of participation set forth in the federal regulations. . . . In addition, the contracting parties may wish to set forth certain policies which will assure that all components share the same general objectives and orientations toward patient care." Whether such agreements are binding contracts depends on the peculiarities of local and state laws. She recommends therefore that the parties have their attorneys prepare a contractual agreement that would be binding in their locality.

Psychiatric News: Official Paper of the American Psychiatric Association, Vol 4, No. 1 (January, 1969)

Stelazine was the medication I was on for many years.

Stelazine was prescribed for schizophrenia.

Schizophrenia is commonly considered to be a serious and incurable mental illness of some sort that elicits a great deal of fear in the general public.

But schizophrenia is simply **a blanket term for a cluster of behaviours** that no medical professional has managed to explain yet. Nothing more than a made up word with a list of behaviours and thinking associated with it.

Reactions.

Originally called a reaction in the DSM-I.

Schizophrenic reaction.

As it turned out, "**the demon"** (it's worth having a look at the language used as well) was never "only in my mind" and addressing the root causes of my mental distress healed me in full.

The forerunners of psychoanalysis were right.

Again.

In addition, Stelazine worked perfectly well to minimize the reactions caused by my trauma and cost around R120 (roughly $7.50) per month.

In 2018, Stelazine was discontinued and its replacement, Seroquel, hit the market for just under R1000 ($65) a month.

It was at this exact time that my recovery into full mental health began in earnest. I decided not to take the new medication because I couldn't afford it and was also afraid of possible side effects.

And I began to focus on managing my reactions naturally instead.

Please do not do this without the consent and support of trained professionals. It is extremely dangerous.

What followed was an experiential journey of three very difficult years into finding and addressing the root causes of my mental health challenges. **And healing them**.

It was only when I stopped taking any mind altering substances (including the prescription medication that was supposed to be helping me) that I was able to observe my reactions clearly enough to make connections as to what “triggered” them.

Over time, I was able to create a map of sorts and find my primary traumas. A “map of sorts” because trauma becomes a network of mini “events”, over time, if it is not processed as soon as possible after the primary traumatic event or situation.

If one addresses the primary trauma, in my personal experience, it takes care of any other events where the primary traumas were unconsciously repeated or recreated.

As Jung said:

> *“Until you make the unconscious conscious,*
> *it will direct your life and you will call it fate.”*

The forerunners in mental health were totally correct in my case as well.

There were only two primary traumas that I needed to address (as it turned out) and neither of them were intentionally created by the people involved. My parents. Good people who had unresolved trauma themselves.

I will explain more how this works in the following chapters.

Back to the American Psychiatric Association’s News and the enormous amount of advertising space being sold to pharmaceutical companies.

This next advertisement only makes me sad.

the homecoming may be sooner

Successful modification of such symptoms as excitement, hypermotility, abnormal initiative, affective tension and agitation is often the prerequisite for—and the beginning of—the process of recovery. Through its inhibitory effect on psychomotor functions, Mellaril may markedly reduce these symptoms, thus facilitating therapy and custodial care. Mellaril helps provide the respite needed to strengthen emotional and physical resources ☐ can be used with confidence in long-term therapy ☐ alleviates somatic complaints triggered by anxiety.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: Central Nervous System—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. Autonomic Nervous System—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. Endocrine System—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. Skin—Dermatitis and skin eruptions of the urticarial type, photosensitivity. Cardiovascular System—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. Other—A single case described as parotid swelling.

the ultimate goal of psychiatric rehabilitation often can be realized more readily with the help of

Mellaril®
(thioridazine HCl)

SANDOZ

67-354R

Psychiatric News: Official Paper of the American Psychiatric Association, Vol 4, No. 1 (January, 1969)

Here we see the onset of a pathologizing of childrens' behaviour begin.

And parents possibly opting for the simpler solution of medicating their children (being encouraged by the mainstream medical profession -and schools - regularly in 2024), instead of addressing possible causes of behaviours.

Reactions (and subsequent behaviours) that could easily be addressed by better quality parenting time, facilitated by assisting and healing parents who were probably suffering from PTSD and C-PTSD after the war.

ADHD?

I no longer believe there is any such “disorder” either.

And I can’t quite wait to show you why.

The pages shown here are from the earliest volume of the Psychiatric News that I could find in the American Psychiatric Association’s newspaper archives.

I wonder what the advertisement ratio was between the first edition to this one and whether there’s an increase in advertising that correlates to an increase in popularity of prescriptions for psychiatric meds in that quarter or year?

Around this same time, another situation had unfolded that also encouraged the use of psychiatric meds..

> *The deinstitutionalization of mental patients, which began in the 1950s and accelerated in the 1960s, posed another challenge to the dynamic perspective of the DSM-I and DSM-II. ...In particular, they seemed to require regimens of drug treatments and supportive social resources…*
>
> *The need of policy makers to respond to the growing number of seriously disturbed patients in community settings further marginalized psychoanalysis and, correspondingly, the diagnostic manual that reflected their assumptions. Psychiatrists were forced partially to shift their attention back to the severely ill patients that had been at the center of attention before the publication of the DSM-I.* [7]

The easiest way to "flatline" people who have severe mental and emotional reactions, is to simply keep them (heavily) medicated.

And, to reiterate, the pharmaceutical industry is a multi-billion dollar business.

Everything mentioned above, according to numerous sources, motivated and influenced the revision of the DSM (DSM-III).

The DSM-III

This manual was very different from the DSM-I and DSM-II. It featured precise, symptom-based classifications, not perfunctory definitions.

> *The number of diagnoses grew from 182 to 265 and the manual itself burgeoned from 134 to 494 pages.*[7]

That's a lot of new "disorders" voted into existence for just one revision, isn't it?!

> *The manuals following the DSM-I and DSM-II also facilitated the movement of psychiatry to* ***a pharmacologically oriented specialty that targeted the symptoms of mental disorders, rather than their underlying causes****.* [my boldface] 7

It was in this edition, the DSM-III, that the psychodynamic approach was largely (or completely) abandoned and the word “disorder” replaced the word “neurosis” in full.

The perspective that mental health conditions were understandable reactions, to unprocessed past events and current external situations, that could be treated with psychoanalysis was discarded.

Instead, "disorders" were voted into existence by a task force of nine Caucasian, mostly male, American human beings.

Some of whom may have had an interest in renaming "neuroses" as "disorders" for their own

personal and financial purposes.

Or who may have been under some encouragement to do so by external parties.

Robert Spitzer on DSM-III: A Recently Recovered Interview

By Christopher Lane, PhD - February 26, 2022 32

> **Lane:** *Let's go back to the key issue of pathologizing and de-pathologizing. Taking you further back to 1968, if I may, with the publication of DSM-II, you co-published with Paul Wilson "A Guide to the APA's New Diagnostic Nomenclature." The article is of great interest to me because in it you discuss "the elimination of the word 'reaction' from labels such as 'schizophrenic reaction,' 'paranoid reaction,'" and so on—a major development, surely, in how we conceptualize and describe psychiatric diagnosis. Was there lengthy discussion at the time about making that change?* [32]
>
> **Spitzer**: *About doing that? No, there was no discussion at all. No, no. You have to understand: the APA had decided with DSM-II to use the ICD-8. The ICD-8 was written by one person, [Sir] Aubrey Lewis at the Maudsley [Institute of Psychiatry, London], and he didn't have the word reaction so, for us, there was never any discussion.* [32]

Apologies. I need to interject here and point to this as a matter of interest: (**Sir Aubrey Lewis**)

> *Lewis was a member of the Eugenics Society. A chapter he contributed to a 1934 book on 'The Chances of Morbid Inheritance', edited by Carlos Blacker, has been described as*

'remarkable for its total admiration for the German work and workers", including Ernst Rudin. [33]

Ernst Rüdin (19 April 1874 – 22 October 1952)[1] was a Swiss-born German psychiatrist, geneticist, eugenicist and Nazi [34]

Let's just look at this again:

Spitzer: *About doing that? No, there was no discussion at all. No, no. You have to understand: the APA had decided with DSM-II to use the ICD-8. The ICD-8 was written by one person, [Sir] Aubrey Lewis at the Maudsley [Institute of Psychiatry, London], and he didn't have the word reaction so, for us, there was never any discussion.* [32]

Lane: *But deleting the word reaction from quite a few designated kinds of mental illness—in a diagnostic manual that's also meant to define them and for clinicians to recognize them—is still a major shift because it's altering the ontological status of the condition …* [32]

Spitzer: *Yes. Yes, it is a major shift. I think if there had been any discussion, it would be in the order of 'We don't add anything by just putting the word reaction to everything.' You can still believe in psycho-biology without having the word [reaction] there. That would have been the argument. But I doubt there was any argument, because by that time, just having the word reaction didn't mean very much.* [32]

Lane: *Except that removing it meant you were in effect turning a reaction to something into more like a lasting, possibly lifelong state. One without an obvious cause, in that you also removed stressors that might be tied to environment, economic status, family dynamics, and so on …* [32]

Spitzer: *Well, what we were saying is 'Dropping the word reaction doesn't really mean anything.' I think that's probably true—I don't think it did mean very much. With DSM-III there were huge controversies over this and other*

> *developments when it came out. But with DSM-II, I guess there was one article, possibly in a newspaper, where William Menninger suggested that by adopting [European-based] ICD-8 we're losing the contribution of American psychiatry. Now whether he was responding to the reaction thing I don't recall. I know there was that one complaint.* [32]

This is Spitzer's reply?

That removing the word reactions "doesn't really mean anything"?

He didn't "think it did mean very much"?

This is his reply to Lane correctly stating:

> "Except that removing it meant you were in effect turning a reaction to something into more like a lasting, possibly lifelong state. One without an obvious cause, in that you also removed stressors that might be tied to environment, economic status, family dynamics,and so on …" [32]

As the DSM went through a few more revisions and subsequent editions, the problems with the manual became ever more evident.

The DSM-5

> *The DSM-5, was published in 2013; it is a massive 947-page tome that defines about 300 conditions in precise detail .* [35]
>
> *The imposing nature of the extant DSM-5, however, disguises the intense uncertainty, factionalism, hostility, and political wrangling that has accompanied the development of each DSM since its third edition in 1980.* [35]
>
> *The bitter controversies that marked the DSM's latest revision sunk the credibility of the manual to levels not seen since the anti-psychiatric climate that marked the 1960s and 1970s. The new critics of the DSM-5 were not the anti-psychiatrists, feminists, and gay advocates who objected to earlier versions* ***but eminent figures within the profession including former NIMH directors and the leaders of the DSM-5 Task Force itself****.* [my boldface] 35

People who were educated and skilled enough to be concerned. People who were privy to the inner workings of the task force selected for the new edition.

> *…it was discovered that the organization that produces the DSM— the APA — receives substantial drug industry funding and that the majority of individuals who serve as diagnostic and treatment panel members also have drug industry ties (Cosgrove et al. 2009, 228–32).* 36
>
> *The fact that 100 percent of the individuals in two DSM panels (Schizophrenia and Psychotic Disorders; Mood Disorders), for example, had financial ties with industry [my boldface] (e.g., served on speakers' bureaus, corporate boards, received honoraria) is particularly problematic because psychopharmacology is the standard treatment in these two categories of disorders.(Cosgrove et al. 2006, 154–60).* [36]
>
> *... the APA instituted a conflict of interest policy for the first time in its more than fifty-five-year history. However, of the twenty-seven task force members who will oversee the development of the DSM-V, only eight reported no industry relationships. When 70 percent of the task force members for the DSM-V have industry ties [my boldface] (representing a relative increase of more than 20 percent compared to the DSM-IV), it is obvious that*

> *disclosure alone is not enough of a safeguard for restoring public trust or protecting patients' welfare (Cosgrove, Bursztajn, and Krimsky 2009, 2035–37).* [36]
>
> *Despite increased transparency, financial relationships between DSM panel members and the pharmaceutical companies that manufacture psychotropic drugs persist.* [36]

This is “the bible of psychiatry and psychology" and the main instrument the majority of mental health professionals rely on to "diagnose" their "patients".

A book containing a variety of mental disorders that are voted into existence by the task forces mentioned above.

Voted into existence disorders that are now, generally believed to be, “chronic medical illnesses” that require chronic psychiatric medications for lifetimes of management.

How Disorders are created

A disorder is voted into existence.

For each version of the DSM, a task force is selected to vote unanimously on what thoughts,feelings and set of behaviours should be considered “disordered” to begin with.

This is not hard science.

This is opinion.

And opinion is always guided by current societal “norms”, politics and personal perspective.

And personal perspective is often influenced by personal motivation.

And personal motivation is regularly skewed by personal gain.

Even if that personal gain is simply to avoid being ostracized by a community or fraternity.

The "disorders" in the DSM are opinions.

Opinion and a perspective that can be – and at times has been – swayed by the pharmaceutical industry.

The task force, allocated to revising the DSM, is required to vote unanimously on what a "disorder" should be named and what criteria the “symptoms” of the “disorder” should be adhered to (duration, number, etc.) for a proper "diagnosis" to be made.

The size of the task force has varied from between 9 to to around 30 professionals, per task force committee, over the years.

A very small portion of a very specific demographic, of a relative handful of psychiatrists, psychologists and associated parties of the United States of America.

Although the DSM is the classification manual of mental disorders by and for the U.S.A., it is used, globally, by a variety of other countries as the “Bible of psychiatry and psychology” as well.

It is even given to students in European countries that follow WHO’s ICD more closely as a diagnostic reference. These students still have the DSM included in their course material during their studies.

Here are some facts about revisions in DSM, over the years, so you can get a sense of how this works.

1. Hysteria - once considered to be a problem associated with only women. The word hysteria originates from the Greek word for uterus - Hysteria was finally removed from the DSM as a disorder in **1980**

2. BPD, borderline personality disorder - added to the DSM in **1980**

3. Controversial diagnoses, such as premenstrual dysphoric disorder (PMT as we commonly refer to it) and masochistic personality disorder, were considered and

discarded

4. Homosexuality was removed from the DSM as a personality disorder in **1973**; kept in as "ego-dystonic homosexuality" and a variety of other classifications, over the revisions, until it was removed as "gender identity disorder" in 2013. It has, however, been replaced with "gender dysphoria". (yes - it is still listed in the Diagnostic statistical manual of mental disorders in 2022)

5. DSM-5 : childhood-onset fluency disorder (a new "disorder" name for stuttering)

6. … change was announced earlier this week as part of the newest version of the manual, the ICD-11. The removal of “transsexualism” means transgender people will no longer be classified as having a mental illness by the WHO… The diagnosis of “transsexualism” was renamed “gender incongruence” and moved from the “Mental and Behavioral Disorders” chapter to the “Conditions Related to Sexual Health” chapter. Still listed in the International Classifications of Disease manual in 2022. [37]

7. Autism was originally described as a form of childhood schizophrenia and the result of cold parenting, then as a set of related developmental disorders, and finally as a spectrum condition with wide-ranging degrees of impairment. Along with these shifting views, its diagnostic criteria have changed as well. [38]

8. In the DSM-II, in 1968, dissociative identity disorder was called hysterical neurosis, dissociative type and was defined as an alteration to consciousness and identity. In 1980, the DSM-III was published and the term "dissociative" was first introduced as a class of disorders.The DSM-IV, in 1994, addressed this somewhat as it included the specific criterion of amnesia to the diagnosis of multiple personality disorder, now renamed to dissociative identity disorder. [39]

9. The terminology used to describe the symptoms of Attention-Deficit Hyperactivity Disorder, or ADHD, has gone through many changes over history, including "minimal brain damage", "minimal brain dysfunction", "learning/behavioral disabilities" and "hyperactivity". [40]

10. DSM-5: Caffeine Withdrawal

11. Paradoxically, although hypersexual disorder was rejected by the American Psychiatric Association for DSM-5, on 1 October 2015 the use of the diagnostic codes of ICD-10 became obligatory in the United States, enabling its diagnosis.

These codes are included in parentheses and gray text in DSM-5 next to the DSM-9-CM codes presented in bold type

12. In the ICD-10, the category ‘excessive sexual drive’ was included as F52.7; this category, which **reflects dated and pejorative terminology** [my boldface], is: [41]

> “Both men and women may occasionally complain of excessive sexual drive as a problem in its own right, usually during late teenage or early adulthood. When the excessive sexual drive is secondary to an affective disorder (F30-F39), or when it occurs during the early stages of dementia (F00-F03), the underlying disorder should be coded. Includes: nymphomania satyriasis.”[41]

The ICD was not much better, although it does seem to have diverted from the DSM towards a more trauma informed approach recently.

In case you're wondering why there is a "CM" on the end (DSM-9-CM in paragraph 11), there are ICD-CM codes as well. The ICD-10-CM is the version of the ICD used in the U.S.A.

This version allows non-physicians (including social workers, nurses, case managers etc) to add codes that are not included in the ICD-10-CM.

New codes can be added, by people in care services, for health concerns created by social, economic, or psychological factors that are not included in clinical diagnoses.

Here we have people who are not doctors (just as we did during the 1840 Census), assigning new codes for what they perceive to be medical conditions.

Statistically these codes have not often been used in inpatient settings, other than for mental health or alcohol/substance use care.

The revision (to the DSM-III) clearly seems to have been more directed towards protecting the income of psychiatrists and to further their standing in the medical community, than it was towards more effectively treating "patients".

By facilitating claims from insurance companies, to increase affordability of treatment for potential clients. And to support more psychiatric and pharmaceutical research. And for approval of pharmaceutical medications by the FDA for so-called mental “illnesses”.

All of the above was set into motion by assigning people with incurable, voted into existence, medical “disorders” that prolong or prevent cure.

On subsequent revisions of the manual, direct ties between members of the task forces with the pharmaceutical industry became glaringly apparent and a major cause for concern.

Why, then, is the DSM still being used by clinicians wanting to actually help people with mental health challenges?

Why are a vast majority of students of psychiatry and psychology (globally) still being given this one book, as a standard text and their "Bible", to diagnose people with these mental health “disorders”?

And does their education include a history of the DSM, in order for them to make an informed decision about what perspective and resultant approach they may prefer to adopt… to treat (and actually possibly heal) people?

As Jung did with Sabina Nikolayevna Spielrein.

"The Cycle of Classification: DSM-I Through DSM-5"

Table 1 Description of the editions of the *Diagnostic and Statistical Manual of Mental Disorders*

Edition	Publication date	Number of pages	Number of diagnoses	Revenue for the American Psychiatric Association
DSM-I	1952	132	128	Unknown
DSM-II	1968	119	193	$1.27 million
DSM-III	1980	494	228	$9.33 million
DSM-III-R	1987	567	253	$16.65 million
DSM-IV	1994	886	383	$120 million
DSM-IV-TR	2000	943	383	Unknown
DSM-5	2013	947	541	Unknown

materials (e.g., a diagnostic flowchart) that could be useful to clinicians and to public health officials (e.g., tables showing how the DSM-III categories matched with ICD-8 categories).

There were 228 categories of mental disorders in the DSM-III (163 categories defined using diagnostic criteria) discussed in 494 pages, making the size of the DSM-III much larger than either the DSM-I or DSM-II. The price of the DSM-III increased ninefold ($31.75). As shown in

Table from: The Cycle of Classification : DSM-I Through DSM-5

Jacqueline L. Tilley, K. Blackwell, P. Mortensen Published 2014 Psychology

https://pubmed.ncbi.nlm.nih.gov/24679178 (https://pubmed.ncbi.nlm.nih.gov/24679178)

Information on the psychiatric pharmaceutical industry

The U.S. pharmaceutical industry is one of the most profitable industries in the history of the world, averaging a return of 17 percent on revenue over the last quarter century. Drug costs have been the most rapidly rising element in health care spending in recent years. Antidepressant medications rank third in pharmaceutical sales worldwide, with $13.4 billion in sales last year alone. This represents 4.2 percent of all pharmaceutical sales globally.

Antipsychotic medications generated $6.5 billion in revenue. [42]

I'll finish off with some thoughts from far more educated and eloquent minds than mine.

There are many great thinkers in the field of psychology. Now largely forgotten by an industry that has medicalised these reactions as "disorders" and mental "illnesses".

An industry that, in 2022, chooses to diagnose chronic psychiatric "illnesses" within first 45 minute sessions and to medicate people (possibly for life) as standard practice…

instead of addressing the primary causes of distress.

Even though there are still many psychiatrists, psychologists, sociologists and anthropologists who suggest a return to a more traditional perspective on mental health and treatment of these challenges.

> *Additionally to the concept of mental disorder, some people have argued for a return to the old fashioned concept of nervous illness. In How Everyone Became Depressed: The Rise and Fall of the Nervous Breakdown (2013), Edward Shorter, a professor of psychiatry and the history of medicine, says:* [43]
>
> > *"About half of them are depressed. Or at least that is the diagnosis that they got when they were put on antidepressants. ... There is a term for what they have, and it is a good old fashioned term that has gone out of use. They have nerves or* ***a nervous illness*** *[my boldface]. 43*
> >
> > *Since the 1980s, Paula Caplan has been concerned about the subjectivity of psychiatric diagnosis, and people being arbitrarily "slapped with a psychiatric label." Caplan says because psychiatric diagnosis is unregulated, doctors are not required*

to spend much time interviewing patients or to seek a second opinion. The Diagnostic and Statistical Manual of Mental Disorders can lead a psychiatrist to focus on narrow checklists of symptoms, with little consideration of what is actually causing the person's problems. [43]

So, according to Caplan, ***getting a psychiatric diagnosis and label often stands in the way of recovery*** [boldface]. [43]

In 2013, psychiatrist Allen Frances wrote a paper entitled 'The New Crisis of Confidence in Psychiatric Diagnosis", which said that "psychiatric diagnosis... still relies exclusively on fallible subjective judgments rather than objective biological tests." Frances was also concerned about "unpredictable overdiagnosis." [43]

For many years, marginalized psychiatrists (such as Peter Breggin, Thomas Szasz) and outside critics (such as Stuart A. Kirk) have "been accusing psychiatry of engaging in ***the systematic medicalization of normality."*** *[my boldface] More recently these concerns have come from insiders who have worked for and promoted the American Psychiatric Association (e.g.,* ***Robert Spitzer****, [my boldface] Allen Frances).* [43]

A 2002 editorial in the British Medical Journal warned of inappropriate medicalization leading to disease mongering, where the boundaries of the definition of illnesses are expanded to include personal problems as medical problems or risks of diseases are emphasized ***to broaden the market for medications****. [my boldface]* [43]

Gary Greenberg, a psychoanalyst, in his book "the Book of Woe", argues that mental illness is really about suffering and how the DSM creates diagnostic labels to categorize people's suffering. [43]

Indeed, the psychiatrist Thomas Szasz, in his book "the Medicalization of Everyday Life", also argues that what is psychiatric illness, is not always biological in nature (i.e. social problems, poverty, etc.), and may even be a part of the human condition. [43]

And my all time favourite:

> *“I'm not critical of the people who do psychotherapy. The therapists in the trenches have to face an awful lot of the social, political, and economic failures of capitalism. I am attacking the theories of psychotherapy. You don't attack the grunts of Vietnam; you blame the theory behind the war. Nobody who fought in that war was at fault. It was the war itself that was at fault. It's the same thing with psychotherapy.* [44]
>
> *It makes every problem a subjective, inner problem. And that's not where the problems come from. They come from the environment, the cities, the economy, the racism. They come from architecture, school systems, capitalism, exploitation. They come from many places that psychotherapy does not address.* [44]
>
> *Psychotherapy theory turns it all on you: you are the one who is wrong. What I'm trying to say is that, if a kid is having trouble or is discouraged, the problem is not just inside the kid; it's also in the system, the society.”* [44]
>
> - James Hillman

It's time we asked "why?" again

What if Sigmund Freud, Carl Jung and other great minds and forerunners of this discovery into the "whys?" of mental health challenges were right all along?

What if these "disorders" are simply reactions to past experience, current external circumstances and an underlying anxiety (neurosis) because of them?

What if, by helping a person process whatever experiences provoke these reactions and teaching them more positive behaviours, these reactions can be minimized or completely eradicated?

What if life has become infinitely more stressful and most households need dual income to get by?

What if healing primary root causes of these reactions takes time and people can't afford to miss work for long periods?

What if treatment options are expensive and state ones are overwhelmed?

What if private medical insurance only pays for three weeks of treatment and the State can only afford the same duration?

What if treatment facilities only have around three weeks to stabilize people, to get them back to work, and proper recovery and healing for these conditions takes time?

What if the quickest way to get people out of treatment and back to work or school is to diagnose an incurable disorder and medicate them with pharmaceuticals?

And the pharmaceutical industry is one of the most lucrative industries in the world?

What if mental health and addiction have become so stigmatized that most people are afraid to even ask these questions or have this conversation?

What if we've been led to believe that these are medical conditions and doctors know how to treat medical conditions so we should simply trust their judgment?

What if a vast majority of students of psychiatry and psychology are given one book to refer to in treating mental health challenges and are told it is their "Bible of psychiatry and psychology"?

And the remaining students, globally, are also given this book as additional study material during

their education?

And what if the majority of mental health professionals and therapists now also believe mental health challenges are incurable disorders as a result of this?

I went back to the beginning and took the “Psychodynamic” approach to understanding my trauma induced reactions.

I took a different approach to getting well after I understood what a “diagnosis” was supposed to be. And when I learned that my “diagnoses” were only a category name, given to a list of reactions.

I worked for three tough years to find the root causes of my reactions and focused on recovery for those alone.

I am now five years medication-free with no further support groups, therapists or treatment necessary.

This… when I was repeatedly told, by leading mental health professionals and / or support groups, that I had some kind of disorder (or another), or disease…

and I would need chronic medication or work programs of management for life.

But I only began to make relevant connections to my primary traumas, and progress substantially, when I fully understood what trauma actually is.

And how trauma “works”.

Ch 2 : Citations

[1] American Psychiatric Association. (n.d.). Psychiatry.org. DSM History. psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

[2] Little, B. (2019, May 15). The 1840 U.S. Census was overly interested in americans' mental health. history.com/news/census-change-mental-illness-controversy.

[3] Gauthier, J. (n.d.). 1840 - History. U.S. Census Bureau. census.gov/history/www/through_the_decades/index_of_questions/1840_1.html.

[4] Whoriskey, P. (2020, October 17). The bogus U.S. census numbers showing slavery's 'wonderful influence' on the enslaved. The Washington Post. washingtonpost.com/history/2020/10/17/1840-census-slavery-insanity.

[5] American Psychiatric Association. (n.d.). Psychiatry.org. DSM History. psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm.

[6] Contributors to Wikimedia projects. (2022e, June 10). American psychiatric association. Wikipedia. ; en.wikipedia.org/wiki/American_Psychiatric_Association.

[7] Horwitz, A. V. (2014). DSM-Iv and DSM-II. In The Encyclopedia of Clinical Psychology (pp. 1–6). John Wiley & Sons, Inc. dx.doi.org/10.1002/9781118625392.wbecp012.

[8] Lobotomy. (n.d.). Encyclopedia Britannica. Retrieved May 24, 2022, from britannica.com/science/lobotomy.

[9] International classification of diseases. (n.d.). Encyclopedia Britannica. Retrieved June 23, 2022, from https://www.britannica.com/topic/International-Classification-of-Diseases.

[10] Hirsch, J. A., Nicola, G., McGinty, G., Liu, R. W., Barr, R. M., Chittle, M. D., & Manchikanti, L. (2016). ICD-10: History and context. AJNR: American Journal of Neuroradiology, 37(4). https://doi.org/10.3174/ajnr.A4696.

[11] Contributors to Wikimedia projects. (2022, June 23). Nosology. Wikipedia. https://en.wikipedia.org/wiki/Nosology.

[12] Contributors to Wikimedia projects. (2022a, April 7). François Boissier de Sauvages de Lacroix. Wikipedia. https://en.wikipedia.org/wiki/Fran%C3%A7ois_Boissier_de_Sauvages_de_Lacroix.

[13] Contributors to Wikimedia projects. (2022b, May 3). Philippe Pinel. Wikipedia. https://en.wikipedia.org/wiki/Philippe_Pinel.

[14] Hirsch, J. A., Nicola, G., McGinty, G., Liu, R. W., Barr, R. M., Chittle, M. D., & Manchikanti, L. (2016a). ICD-10: History and context. AJNR: American Journal of Neuroradiology, 37(4). https://doi.org/10.3174/ajnr.A4696

[15] Statistics, N. C. for H. (n.d.). History of the statistical classification of diseases and causes of death (2011).

[16] CDN.WHO.INT History of the development of the ICD https://cdn.who.int/media/docs/default-source/classification/icd/historyoficd.pdf and link to file download and snapshot

[17] Lewes, F. M. M. (1988). Dr Marc d'Espine's statistical nosology. Medical History, 32(3), 301–313. https://doi.org/10.1017/s0025727300048250

[18] History ICD-10-WHO - ILCD to ICD-10. (n.d.-b). BFARMWEB. Retrieved October 21, 2022, from

https://www.bfarm.de/EN/Code-systems/Classifications/ICD/ICD-10-WHO/History/ilcd-to-icd-10.

[19] Raminani, S. R. (2013, September 11). International classification of diseases. Encyclopedia Britannica.

[20] Psychiatry.org. (n.d.). DSM History. Retrieved October 21, 2022, from https://psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm

[21] The Editors of Encyclopaedia Britannica. (1998, July 20). Jacques Bertillon. Encyclopedia Britannica. https://www.britannica.com/biography/Jacques-Bertillon

[22] APA dictionary of psychology. (n.d.). Retrieved May 20, 2022, from dictionary.apa.org/psychosocial.

[23] Upton, J. (n.d.). Psychosocial factors. SpringerLink. Retrieved May 20, 2022, from link.springer.com/referenceworkentry/10.1007/978-1-4419-1005-9_422.

[24] Dictionary, C. (n.d.). neurosis. Meaning in the Cambridge English Dictionary. dictionary.cambridge.org/dictionary/english/neurosis.

[25] Felman, A. (2018, January 9). Neuroses and neuroticism: What's the difference? Medical News Today. medicalnewstoday.com/articles/246608

[26] DSM-I diagnostic and statistical manual: Mental disorders. (1952)

[27] Contributors to Wikimedia projects. (2022a, April 28). Sabina spielrein. Wikipedia. en.wikipedia.org/wiki/Sabina_Spielrein.

[28] O'Connor, C. (2011, April 13). Rethinking psychiatry - The Source - Washington University in St. Louis. The Source. source.wustl.edu/2011/04/rethinking-psychiatry.

[29] International Medical Aid. (2021, August 9). The difference between psychiatry and psychology. International Medical Aid.

[30] Contributors to Wikimedia projects. (2022d, October 7). Robert spitzer (psychiatrist). Wikipedia. https://en.wikipedia.org/wiki/Robert_Spitzer_(psychiatrist)

[31] Scientific review of mental health practice. (n.d.). Retrieved October 21, 2022, from https://www.srmhp.org/0401/spitzer.html

[32] Lane, C. (2022, February 26). Robert spitzer on DSM-III: A recently recovered interview. Mad In America. https://www.madinamerica.com/2022/02/robert-spitzer-dsm.

[33] Contributors to Wikimedia projects. (2022d, August 24). Aubrey Lewis. Wikipedia. https://en.wikipedia.org/wiki/Aubrey_Lewis

[34] Contributors to Wikimedia projects. (2022f, October 19). Ernst Rüdin. Wikipedia. https://en.wikipedia.org/wiki/Ernst_R%C3%BCdin

[35] DSM: A history of psychiatry's bible. (n.d.). Hopkins Press. Retrieved October 21, 2022, from https://www.press.jhu.edu/newsroom/dsm-history-psychiatrys-bible.

[36] Cosgrove, Lisa The DSM, big pharma, and clinical practice guidelines: Protecting patient autonomy and informed consent. (December 2016) ; uh.edu/ethicsinscience/Media/dsm-bigpharma.pdf.

[37] Fitzsimons, T. (2018, June 20). "Transsexualism" removed from World Health Organization's disease manual. NBC News. ; nbcnews.com/feature/nbc-out/transsexualism-removed-world-health-organization-s-disease-manual-n885141.

[38] Zeldovich, L. (2018, May 9). Autism diagnosis — The evolution of "autism" as a diagnosis, explained. Spectrum | Autism Research News. https://www.spectrumnews.org/news/evolution-autism-diagnosis-explained/

[39] Tracey, N. (n.d.). The amazing history of dissociative identity disorder (DID). HealthyPlace. Retrieved May 19, 2022, from healthyplace.com/abuse/dissociative-identity-disorder/the-amazing-history-of-dissociative-identity-disorder-did.

[40] Contributors to Wikimedia projects. (2021, November 12). History of attention deficit hyperactivity disorder. Wikipedia, wiki/History_of_attention_deficit_hyperactivity_disorder.

[41] Krueger, R. B. (2016). Diagnosis of hypersexual or compulsive sexual behavior can be made using ICD-10 and DSM-5 despite rejection of this diagnosis by the American Psychiatric Association. Addiction, 111(12), 2110–2111. doi.org/10.1111/add.13366.

[42] Sharfstein, S. S. (2005). Big pharma and American psychiatry: The good, the bad, and the ugly. Psychiatric News, 40(16), 3–4. doi.org/10.1176/pn.40.16.00400003.

[43] Contributors to Wikimedia projects. (2022d, May 20). Mental disorder. Wikipedia. en.wikipedia.org/wiki/Mental_disorder.

[44] On soul, character and calling : A conversation with james hillman. (n.d.). Retrieved June 21, 2022, from scott.london/interviews/hillman.html.

Ch 2 : Bibliography

1. Dean, C. E. (2020). The Skeptical Professional's guide to psychiatry: On the risks and benefits of antipsychotics, antidepressants, psychiatric diagnoses, and neuromania. Routledge.

2. Decker, H. S. (2013). The Making of DSM-III: A diagnostic manual's conquest of American psychiatry. Oxford University Press.

3. Phillips, J. (n.d.). Issue 30, vol 17, #2.

4. (N.d.). Retrieved October 23, 2022, from https://world-news-research.com/makingmodpsychology.html

1. aifc. (2016, March 3). 15 new disorders in the DSM-5. Aifc. https://www.aifc.com.au/14-new-disorders-in-the-dsm-5/

2. al), G. B. (et. (n.d.). Toward a theory of schizophrenia.

3. Alharbi, M. A., Isouard, G., & Tolchard, B. (2021). Historical development of the statistical classification of causes of death and diseases. Cogent Medicine, 8(1). https://doi.org/10.1080/2331205x.2021.1893422

4. American Psychiatric Association "HIghlights of Changes from the DSM-IV-TR to DSM-5 (2013) https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Changes_from_DSM-IV-TR_-to_DSM-5.pdf

5. Bowlby, J. (n.d.). Retrieved October 22, 2022, from https://mindsplain.com/wp-content/uploads/2020/08/ATTACHMENT_AND_LOSS_VOLUME_I_ATTACHMENT.pdf

6. Bowlby's 44 thieves study. (n.d.). Scribd. Retrieved October 22, 2022, from

https://www.scribd.com/document/111158750/Bowlby-s-44-Thieves-Study

7. Bresnick, J. (2018, June 13). ICD-10 Allows non-physician documentation of social determinants. HealthITAnalytics. https://healthitanalytics.com/news/icd-10-allows-non-physician-documentation-of-social-determinants

8. Brief history of WHO. (n.d.). Credible Voice: WHO-Beijing and the SARS Crisis. Retrieved October 22, 2022, from https://ccnmtl.columbia.edu/projects/caseconsortium/casestudies/112/casestudy/www/layout/case_id_112_id_776.html

9. Cassidy, J., Jones, J. D., & Shaver, P. R. (2013). Contributions of attachment theory and research: A framework for future research, translation, and policy. Development and Psychopathology, 25(4 0 2). https://doi.org/10.1017/S0954579413000692

10. Contributors to Wikimedia projects. (2022a, September 1). G. Stanley Hall. Wikipedia. https://en.wikipedia.org/wiki/G._Stanley_Hall

11. Contributors to Wikimedia projects. (2022b, October 6). Homosexuality in the DSM. Wikipedia. https://en.wikipedia.org/wiki/Homosexuality_in_the_DSM

12. Contributors to Wikimedia projects. (2022c, May 18). Lobotomy. Wikipedia. en.wikipedia.org/wiki/Lobotomy.

13. Contributors to Wikimedia projects. (2022c, October 12). Psychiatric medication. Wikipedia. https://en.wikipedia.org/wiki/Psychiatric_medication

14. Contributors to Wikimedia projects. (2022d, October 13). Wilhelm reich. Wikipedia. https://en.wikipedia.org/wiki/Wilhelm_Reich

15. Cosgrove, L., The DSM, big pharma, and clinical practice guidelines: Protecting patient autonomy and informed consent Source: International Journal of Feminist Approaches to Bioethics, Vol. 4, No. 1, Special Issue: Feminist Perspectives on Ethics in Psychiatry (Spring 2011), pp. 11-25 Published by: University of Toronto Press

16. Cosgrove, L., & Krimsky, S. (2012). A comparison of DSM-IV and DSM-5 panel members' financial associations with industry: A pernicious problem persists. PLoS Medicine, 9(3). https://doi.org/10.1371/journal.pmed.1001190

17. Cosgrove, L., & Riddle, B. (2003). Constructions of femininity and experiences of menstrual distress - PubMed. Women & Health, 38(3). https://doi.org/10.1300/J013v38n03_04

18. Dean, C. E. (2020). The Skeptical Professional's guide to psychiatry: On the risks and benefits of antipsychotics, antidepressants, psychiatric diagnoses, and neuromania. Routledge.

19. Global claims views: Australia. (n.d.). DSM5. Retrieved October 21, 2022, from https://www.rgare.com/knowledge-center/media/articles/global-claims-views-australia---dsm5

20. Gregory Bateson's double bind theory. (2018, August 16). Exploring Your Mind. https://exploringyourmind.com/gregory-batesons-double-bind-theory/?fbclid=IwAR0KYiTaCfTuFin0m8RM2UNIkSHu5e_qMU_kpCN68APQK1PITNY-FZZQcEw

21. Horwitz, A. V. (n.d.). Project MUSE - How did everyone get diagnosed with major depressive disorder? Perspectives in Biology and Medicine, 58(1), 105–119. https://doi.org/10.1353/pbm.2015.0005

22. Jaramillo-Gonzalez, L. E., Sanchez-Pedraza, R., & Herazo, M. I. (2014). The frequency of rehospitalization and associated factors in Colombian psychiatric patients: A cohort study. BMC Psychiatry, 14, 161. https://doi.org/10.1186/1471-244X-14-161

23. Jervert, K. (2022, August 9). Loss, grief, and betrayal: Psychiatric survivors reflect on the impact of new serotonin study. Mad In America. https://www.madinamerica.com/2022/08/psychiatric-survivors-reflect-serotonin-study/

24. Jones, K. (2012, February 10). European psychologists voice concerns over new DSM criteria. Medindia.https://www.medindia.net/news/european-psychologists-voice-concerns-over-new-dsm-criteria-97341-1.html

25. Julius Axelrod. (n.d.). Profiles in Science. Retrieved October 21, 2022, from https://profiles.nlm.nih.gov/spotlight/hh

26. Kurbasic, I., Pandza, H., Masic, I., Huseinagic, S., Tandir, S., Alicajic, F., & Toromanovic, S. (2008). The advantages and limitations of international classification of diseases, injuries and causes of death from aspect of existing health care system of Bosnia and Herzegovina. Acta Informatica Medica, 16(3). https://doi.org/10.5455/aim.2008.16.159-161

27. Marston, H. (n.d.). A brief history of psychiatric drug development. Articles. Retrieved October 21, 2022, from https://www.bap.org.uk/articles/a-brief-history-of-psychiatric-drug-development/

28. MIC. (2022, January 28). Kids in crisis: The overprescribing of psychiatric medication. Mad in Canada. https://madincanada.org/2022/01/kids-in-crisis-the-overprescribing-of-psychiatric-medication/

29. Nancy C. Andreasen. (n.d.). Psychology Wiki. Retrieved October 21, 2022, from https://psychology.fandom.com/wiki/Nancy_C._Andreasen

30. Orman, D. J. (n.d.). DSM (The Diagnostic and Statistical Manual of the American Psychiatric Association) - Where did it come from? Medcast. Retrieved October 21, 2022, from https://medcast.com.au/blogs/dsm-the-diagnostic-and-statistical-manual-of-the-american-psychiatric-association-where-did-it-come-from

31. Oyffe, I., Kurs, R., Gelkopf, M., Melamed, Y., & Bleich, A. (2009). Revolving-door patients in a public psychiatric hospital in Israel: Cross sectional study. Croatian Medical Journal, 50(6), 575–582. https://doi.org/10.3325/cmj.2009.50.575

32. Ph.D., J. R. (2022, June 28). An alternative to psychiatric hospitals. Psychology Today. https://www.psychologytoday.com/us/blog/psychiatry-through-the-looking-glass/202206/alternative-psychiatric-hospitals?amp

33. Psychiatric medications kill more americans than heroin - Drug rehab options. (2016, January 6). Rehabs.Com. https://rehabs.com/pro-talk/psychiatric-medications-kill-more-americans-than-heroin/

34. Repnikov, G. (2014). The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry by Hannah S. Decker. Journal of the History of the Neurosciences.

35. reporter, G. staff. (2022, August 3). The chemical imbalance theory of depression is dead – but that doesn't mean antidepressants don't work. The Guardian. https://www.theguardian.com/commentisfree/2022/aug/03/the-chemical-imbalance-theory-of-depression-is-dead-but-that-doesnt-mean-antidepressants-dont-work

36. Rhodes, E. M. and L. A. (n.d.). Resources on the history of psychiatry from the history of medicine of NLM.

37. schizophrenia and the family. (n.d.). Retrieved October 22, 2022, from https://goertzel.org/dynapsyc/1997/Koopmans.html

38. Sexual masochism disorder DSM-5 302.83(F65.51). (n.d.). Therapedia. Retrieved May 19, 2022, from theravive.com/therapedia/sexual-masochism-disorder-dsm--5-302.83(f65.51)

39. Spencer, M. (2022, August 16). Ken Burns' "Hiding in Plain Sight...": Candid interviews, canned

conclusions. Mad In America.
https://www.madinamerica.com/2022/08/ken-burns-hiding-in-plain-sight-youth-mental-illness-review/

40. Spiegel, A. (2004, December 27). The Dictionary of Disorder. The New Yorker.
https://www.newyorker.com/magazine/2005/01/03/the-dictionary-of-disorder

41. Statement on DSM V. (2013, February 11). Mental Health Europe.
https://www.mhe-sme.org/statement-on-dsm-v/

42. Statistics, N. C. for H. (n.d.). History of the statistical classification of diseases and causes of death (2011).

43. The influence of the power of psychiatrists involved in the construction process of autism in the DSM (1952 2013). (n.d.). Retrieved October 22, 2022, from
https://1library.net/document/zgwd90vy-influence-power-psychiatrists-involved-construction-process-autism-dsm.html

44. Werremeyer. (2012). Lithium – Back to the elements. Mental Health Clinician, 2(1), 1–2.
https://doi.org/10.9740/mhc.n110699

45. Whitaker, R. (2020, August 23). An FDA whistleblower's documents: Commerce, corruption and death. Mad In America.
https://www.madinamerica.com/2020/08/fda-whistleblowers-documents-commerce-corruption-death/

46. Whitaker, R. (2022, August 13). Psychiatry, fraud, and the case for a class-action lawsuit. Mad In America. https://www.madinamerica.com/2022/08/psychiatry-fraud-and-the-case-for-a-class-action-lawsuit